Claire L. Wendland, "Exceptional Deliveries: Home Births as Ethical Anomalies in American Obstetrics," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 253-65.

Exceptional Deliveries: Home Births as Ethical Anomalies in American Obstetrics

Claire L. Wendland

ABSTRACT

Interest in home birth appears to be growing among American women, and most obstetricians can expect to encounter patients who are considering home birth. In 2011, the American College of Obstetricians and Gynecologists (ACOG) issued an opinion statement intended to guide obstetricians in responding to such patients.

In this article, I examine the ACOG statement in light of the historical and contemporary clinical realities surrounding home birth in the United States, an examination guided in part by my own experiences as an obstetrician in home-birth-friendly and home-birth-unfriendly medical milieus. Comparison with other guidelines indicates that ACOG treats home birth as an ethical exception: comparable evidence leads to strikingly different recommendations in the case of home birth and the case of trial of labor following a prior cesarean; and ACOG treats other controversial issues that involve similar ethical questions quite differently.

By casting the provision of information as not just the primary but the sole ethical responsibility of the obstetrician, ACOG statement obviates obstetricians' responsibilities to provide appropriate clinical care and to make the safest possible clinical environment for those mothers who choose home birth and for their newborns. What, on its face, seems to be a statement of respect for women's autonomy, implicitly authorizes behaviors that unethically restrain truly autonomous choices. Obstetricians need not attend home births, I argue. Our ethical duties do, however, oblige us (1) to refer clients to skilled clinicians who will attend home birth, (2) to continue respectful antenatal care for those women choosing home birth, (3) to provide appropriate consultation to home birth attendants, and (4) to ensure that transfers of care are smooth and nonpunitive.

I support home birth, and during my years in the clinical practice of obstetrics backed up home birth midwives. Nonetheless, I have never attended a home birth, and do not wish to. The idea of it is uncomfortable—even alarming. During training, I came to see my task as an obstetrician as detecting complications that attend labor, birth, and the early postpartum period: intervening to avert them where possible, and treating them when prevention isn't possible. The job relies heavily on a set of diagnostic and therapeutic tools that includes my senses and extends to ultrasound, an array of medications, various monitors (for the fetal heart rate, for uterine contractions, for oxygen saturation, et cetera), banked blood products, and the operating room. The diagnostic tools are powerful. The therapeutic tools can be lifesaving. The hospital in which those tools are at the ready is a safe, comfortable, and familiar arena where I feel in control. Outside it I would feel at sea at a birth, bored because there is little for me to do, and afraid because if I detected a real or possible complication I would be incapable of intervening in any but the most rudimentary ways while

Claire L. Wendland, PhD, MD, is an Associate Professor in the Departments of Anthropology, Obstetrics and Gynecology, and Medical History and Bioethics at the University of Wisconsin, Madison, *cwendland@wisc.edu.*

awaiting ambulance transport. Boredom and fear are a bad combination.

Many obstetricians, like me, fear home birth. We do not want to attend it, and we do not want to feel responsible for it. Trying to be conscientious clinicians, however, we attempt to set our gut-level responses aside and to make reasoned and ethically sound clinical judgments that draw on medical evidence. Many of us seek assistance from our professional society, the American College of Obstetricians and Gynecologists (ACOG), as we look for paths through the confusing thickets of medical science, epidemiological research, and ethical argumentation. ACOG publishes a range of influential guidelines for its fellows, who include 90 percent of America's board-certified obstetricians. These guidelines typically summarize available research, outline the state of contemporary medical knowledge on a given topic, and guide recommended actions. ACOG's "practice bulletins" and "committee opinions" are intended to guide obstetricians as we face the many dilemmas of practice.

In this article I consider ACOG's committee opinion on home birth, issued in 2011, in light of ACOG's published guidance on other comparable practices. This examination draws upon the recent literature on home birth. It is guided as well by my own aversion to attending home birth, and my experiences in home-birth-friendly and home-birth-unfriendly medical milieus. I argue that ACOG treats home birth as an ethical exception: that is, as a special case for which neither scientific evidence nor ethical principles translate into action in the usual way. Interrogation of these anomalies leads to an alternative vision of ethical practice in relation to home birth. It also leads to a question that deserves reflection: does home birth's anomalous status relate—at least in part—to the complex swirl of feelings engendered in some of us when women reject our obstetrical technologies and embrace birth locations outside of our comfort zone?

HOME BIRTH: NATIONAL TRENDS AND INSTITUTIONAL RESPONSES

Rates of home birth in the United States began a long slow decline in the late 19th century. By 1969, home birth rates were under 1 percent, where they have remained ever since.[1] Within that tiny fraction of American births, the waxing and waning of home birth has attracted considerable attention from mainstream obstetrics.

In the late 1970s, the proportion of out-of-hospital births unexpectedly doubled. That resurgence in some ways presaged today's. It sprang from a diverse range of other cultural shifts including consumer rights, religious movements, feminism, and the back-to-the-land movement. The burst of interest in home birth was part of a historical moment in which a visible minority rejected mainstream social practices in favor of experiences deemed more authentic—or more natural. Absolute numbers of home births remained very small, but the response from mainstream obstetrics was strong. Obstetricians and gynecologists in some communities collectively decided to eject from antenatal care any woman expressing interest in home birth.[2] In 1977 Warren Pearse, then president of ACOG, equated home birth with child abuse.[3] Other obstetricians agreed, claiming that women who delivered at home were selfishly putting their own interests ahead of their children's safety. In the subsequent decades, as the broader cultural changes subsided, so did home birth.

Today interest in home birth is surging again. Media attention to the trend means that home birth looms large in the cultural imagination even though—once again—the actual numbers are small. The incidence of home birth has risen by almost a third in the past five years, but planned home births still remain less than 1 percent of all American births.[4] The causes of this recent rise are poorly understood. Dissatisfaction with impersonal and high-intervention hospital care appears to be one issue, but factors driving the increase in home births are probably multiple, and are beyond the scope of this article. One consequence is that obstetricians in most parts of the country can now expect to encounter patients who are considering home birth.

In an apparent response to the growing public attention to birth choices, ACOG in 2011 issued a committee opinion intended to guide obstetricians whose patients ask about home birth.[5] "Committee Opinion No. 476: Planned Home Birth" notes that little high-quality evidence about the effects of birth location on maternal and neonatal outcomes is available, in the absence of adequate randomized controlled trials.[6] It then briefly summarizes some of the research that *is* available, primarily drawing on a recent meta-analysis of observational studies comparing home and hospital birth. The statement is brief and clear. Identically worded abstracts at the beginning and the end sum up its analysis and recommendations:

> Although the Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed deci-

sion about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse-midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes.[7]

The ACOG Opinion in Broader Perspective

Examining ACOG's committee opinion in a broader context helps us to see the ways in which home birth appears anomalous. We can see the bigger picture in two ways: first, by comparing the committee opinion on home birth to home birth guidelines produced by other professional organizations or proposed by other influential obstetrician-gynecologists; second, by comparing the committee opinion on home birth to committee opinions on other topics.

Professional societies other than ACOG reach variable conclusions about home birth. The American College of Nurse Midwives supports home birth, as does the American Public Health Association (APHA). Several European and Canadian professional societies for obstetrician-gynecologists pronounce home birth to be a reasonable alternative for low-risk women, and one that does not endanger their newborns. The United Kingdom's Royal College of Obstetrics and Gynaecology (RCOG), for instance, issued a joint statement with the Royal College of Midwives noting that "there is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their families. There is ample evidence showing that labouring at home increases a woman's likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby."[8] Meanwhile, the American Medical Association and the American Academy of Pediatrics, like ACOG, recommend against home birth. The point here is not to evaluate who is right and who is wrong; the point is simply to show that professional bodies drawing on the same evidence can reach very different conclusions.

The range of published medical recommendations on home birth is even wider once we move beyond professional societies. On one end of the spectrum, a few obstetricians contend that we are ethically bound to support women's choices to deliver at home. Plante, for instance, decries ACOG's opposition to home birth as part of a broader trend in obstetrics that undermines the rights and power of women: "the industrialization of birth may have consequences which actually decrease women's autonomy and strip choices away."[9]

Others contend that the ACOG statement does not go far enough to discourage home birth. Chervenak and colleagues argue that the lack of integration between home and hospital births means home birth in the United States should be presumed to be much more dangerous than it is in Europe and Canada.[10] Obstetricians may not ethically participate in home births for this reason, they argue. Pregnant women should not elect home birth either, for they are "ethically obligated to authorize and accept" any intervention that is "reliably expected to benefit the fetal patient and child it is expected to become."[11] In the event that a pregnant woman does *not* accept her ethical obligation to hospital birth, her obstetrician must provide directive counseling reminding her of her duties and the risks to which she is exposing her fetus.

In a recent article, Chervenak and colleagues elaborate on these contentions, proposing that a "professional responsibility approach" to ethics mandates that obstetricians not only counsel their patients against home birth, but refrain from participation in research on home birth, from attendance at home birth, and from advocacy for its availability.[12] After summing up what they interpret as the risks of planning a home birth, the authors conclude that "to regard these risks as ethically acceptable relegates pregnant and fetal patients who experience adverse events to the category of collateral damage. It is antithetical to professional responsibility to intentionally assign any damaged or dead pregnant, fetal, or neonatal patient to this category, even if the number is small. Obstetricians who nonetheless do so should be subject to peer review and justifiably incur professional liability and sanction from state medical boards. Policy makers who do so should be exposed as threats to professional responsibility."[13] I will return to this article later, for it provides clues to how and why home birth becomes ethically exceptional for obstetricians.

ACOG, Chervenak and his coauthors, RCOG, the APHA, and others are all reading from the same body of evidence to produce what they clearly consider

to be evidence-backed recommendations for ethical practice. How can the same evidence support such different conclusions?

HOME BIRTH AS EXCEPTION: READING THE EVIDENCE

The evidence cited to support practice guidelines has already passed many hurdles. A potential research question must be asked; it must be feasible to study; it must be funded or otherwise supported; the study must be completed; it must be published; that publication must circulate; and some piece(s) of that circulated evidence must be selected for inclusion. At every point in this chain, some potential evidence is lost. Which evidence disappears, which evidence becomes visible, and which evidence is never considered at all is far from random, as social scientists have pointed out.[14] A study on home birth research in the Netherlands concludes that "mainstream obstetric science follows mainstream obstetric practice,"[15] rather than vice versa, and that the *evidence* of evidence-based medicine "must be seen as a rhetorical justification for whatever particular groups were going to do anyway."[16] As Rooks notes, some practices that are well-supported by evidence (for instance, provision of continuous labor support by a doula—a person trained to provide nonmedical support during childbirth) are seldom applied in obstetrics, while practices with little or no evidentiary support (for example, nasopharyngeal suction of the newborn, continuous fetal monitoring in low-risk labors) become routinized.[17]

What evidence *should* one use to evaluate hospital and home birth in the most evenhanded way? The question has no simple answer. Prospective randomized studies are generally considered ideal evidence in medicine. It has not proven feasible, and may be unethical, to randomize low-risk women to home or hospital birth—the single published randomized trial to report outcomes enrolled only 11 women.[18] Retrospective analyses using birth certificate data, a common way to compare births that happened within and outside of the hospital, can be misleading. Complications that develop during labors at home and necessitate intrapartum transfer will be counted as hospital births, making home birth look safer and hospital birth more dangerous. But birth certificate data also lump together planned home births that are attended by skilled midwives or doctors with unintentional and unassisted out-of-hospital births, thus making home birth look *more* dangerous than it might otherwise. The best comparisons place *planned* home birth against *planned* hospital birth—no matter where the birth ultimately took place—for women with similar risk profiles. Even then, it is difficult (perhaps impossible) to factor in the varying credentials and skills of birth attendants in either location, the patterns of risk screening used, and the factors that may have led women to select home or hospital birth in the first place.

Given these multiple ambiguities, how did ACOG actually mobilize evidence on home birth? The committee opinion emphasized some evidence, converting it into guidelines. It presented other evidence without emphasis. Some potential evidence did not appear at all. A closer look is instructive, because it allows us to compare the evidence used in the case of home birth with the evidence used in other cases.

What Evidence Mattered?

The ACOG's counseling recommendations drew from a single controversial meta-analysis—known informally as the Wax study—that synthesized results from prior research on home birth across North America, Western Europe, and Australia.[19] Table 1 depicts the Wax study's data as presented in the ACOG opinion. The study's most controversial claim was that planned home birth at least doubled, and possibly tripled, neonatal deaths: ACOG highlighted that contentious claim as the centerpiece of obstetricians' counseling for patients considering home birth. The Wax meta-analysis and its claim of increased neonatal deaths in home birth settings drew serious methodological critique from epidemiologists on mathematical, research design, statistical, and analytical grounds; [20] its inclusion of data from unplanned, unattended out-of-hospital births in the "planned home birth" category especially troubled many critics, casting doubt on its conclusions regarding neonatal deaths. The full text of the ACOG's committee opinion also mentioned two additional large cohort studies that showed *lower* risks for neonates in planned home birth.[21] The statement did not summarize those studies' results, did not include them in the abstract, table, or conclusion, and did not recommend that obstetricians cite data from them when advising their patients.

Some data on short-term outcomes for mothers did appear in the statement, but their absence from the conclusion, abstract, or recommendations suggests that they were considered of secondary importance. The table presented in the committee opinion provided estimates of operative vaginal delivery (that is, delivery using forceps or vacuum), ce-

sarean section, lacerations that extend into the anal sphincter or anal canal itself, and maternal infection. All of these were two to four times as likely for women who planned hospital birth as for those who planned home birth. ACOG did not address these differences in its counseling guidelines, although many women would likely find them relevant to their birth choices.

In fact, because the Wax meta-analysis combined studies from the 1950s to the present and included research from countries with different patterns of in-hospital intervention, some findings look very different than the findings that ACOG's doctors and their patients might expect. Most strikingly, the 9.3 percent rate of cesarean in planned hospital birth is, even by conservative estimates, well less than half of what a low-risk American woman planning a hospital birth today could anticipate. ACOG's statement did not draw attention to this anomaly, or to the still markedly increased maternal interventions and complications attending hospital birth. The committee framed only the possibly increased neonatal death rates as critical to counseling patients.

What Evidence Didn't Matter?

Several kinds of evidence that could have been brought to the discussion were absent from the ACOG statement. Maternal psychosocial concerns, effects on the mother-newborn dyad, and long-term outcomes for women went unaddressed. No evidence on costs was cited.

Maternal subjectivity related to planned birth location, whether the sense of power and control that women often report with home birth and sometimes with hospital birth,[22] the distress that can attend an unmedicated labor at home, or the pain of recovery after a large abdominal incision in the hospital, did not appear in the ACOG's statement.

Implications for the maternal-newborn dyad, such as effects on bonding and breast-feeding, also went unmentioned. Research reports positive effects of planned home birth for breast-feeding,[23] and ACOG itself supports breast-feeding.[24]

Long-term outcomes of planned birth location were not addressed at any point in the statement. The substantially lower cesarean rate among those planning home birth, for instance, might have allowed consideration of long-term postoperative complications—or of pelvic floor dysfunction and urinary incontinence, which some researchers believe can be prevented with cesarean. Long-term implications of cesarean are an increasing focus of concern, one that has prompted a recent consensus statement aimed at reducing the use of primary cesarean.[25] As ACOG has recognized in other contexts, the cumulative morbidity and mortality of repeat cesareans are alarming enough that avoiding an initial cesarean is prudent. In this statement, however, implications for subsequent pregnancies or later life went unaddressed.

Because long-term outcomes of birth planning were invisible, the implication was that they were unimportant: home birth was not considered as a source of long-term health protection—or hospital birth as a potential source of long-term harm—for women. ACOG's omission of long-term outcomes in this statement contrasts with its fore grounding of those outcomes in other committee opinions and practice bulletins.

Other Cases, Other Uses of Evidence

Comparing ACOG's use of evidence in its 2011 guidelines on home birth to its use of evidence in other guidelines indicates that its treatment of home birth is anomalous. In table 2, I summarize the kinds of evidence presented in guidelines on non-indi-

TABLE 1. Planned home birth versus planned hospital births, as presented in the ACOG's Committee Opinion

	Planned home birth	Planned hospital birth	Odds ratio	95% confidence interval
Neonatal death—all newborns	2.0/1000	0.9/1000	2.0	1.2 - 3.3
Neonatal death—non-anomalous	1.5/1000	0.4/1000	2.9	1.3 - 6.2
Episiotomy	7.0%	10.4%	0.26	0.24 - 0.28
Operative vaginal delivery	3.5%	10.2%	0.26	0.24 - 0.28
Cesarean delivery	5.0%	9.3%	0.42	0.39 - 0.45
Third- or fourth-degree laceration	1.2%	2.5%	0.38	0.33 - 0.45
Maternal infection	0.7%	2.6%	0.27	0.19 - 0.39

Source: "ACOG Committee Opinion No. 476: Planned home birth," *Obstetrics & Gynecology* 117 (2011): 425-80, table 1.

cated surgery and on trial of labor after cesarean section (TOLAC).[26] ACOG takes some kinds of evidence as self-evidently critical to ethical decision making in the case of home birth, when it is not in other contexts. The guidelines on TOLAC are especially instructive because the cases are in critical respects parallel: for both home birth and TOLAC, weak and contested evidence suggests an increase in neonatal deaths and a decrease in maternal complications.

Labor after a cesarean differs from ordinary labor. Most of the time, a "trial of labor," as it is known, will end in an unremarkable vaginal birth. In rare but potentially catastrophic cases, the uterus ruptures along the old scar line. Certain common obstetrical interventions (such as various forms of labor induction) raise this risk. Fear of uterine rupture led to the old dictum, "once a cesarean, always a cesarean." Recognition of its rarity, and growing concern with the consequences of repeat cesarean section, meant both trials of labor and successful vaginal birth after cesarean increased through the 1980s and 1990s. Since the turn of the millennium, however, obstetrical practice has shifted rapidly back toward repeat cesarean. Institutional barriers now limit the availability of TOLAC in many settings: that is, pregnant women with a prior cesarean section, even those who are very likely to have uneventful deliveries, are permitted no alternative to surgery if they choose to deliver in hospital. Recent surveys indicate that about a third of hospitals and about half of obstetricians will not make TOLAC available at all.[27]

TOLAC is particularly interesting to consider because the evidence is comparable in two key respects to that on home birth: its overall problematic quality, and a balance between clear maternal benefit and a possible increase in neonatal death with both TOLAC and home birth. In both cases, the data on risk and safety are voluminous, mixed, and frustratingly ambiguous on many important points. In both cases, randomized controlled trials are not available and probably never will be. When compared to its alternative course of action, TOLAC combines a two- to threefold risk of neonatal death (by low- to moderate-grade evidence) with a substantially lower risk of medical complications for the mother.[28] For the sake of argument, if we were to accept the Wax study's problematic conclusions about home birth and neonatal death (as ACOG does, although I and many others do not), home birth too appears to combine a two- to threefold risk of neonatal death with a substantially lower risk of medical complications for the mother.

The data are, in important respects, similar, then. Yet ACOG's use of evidence to guide action is quite different in the case of TOLAC than it is for home birth. ACOG's practice bulletin on vaginal birth after cesarean notes and reiterates the call by the National Institutes of Health to make trial of labor available for all women who desire it. While the bulletin does not mandate that individual obstetricians attend trial of labor after cesarean, it notes that obstetricians who are too uncomfortable to do so should refer patients to obstetricians who will, and that "health care providers and insurance carriers should do all they can to facilitate transfer of care or comanagement in support of a desired TOLAC, and such plans should be initiated early in the course of antenatal care."[29]

The ACOG's statement on trial of labor also reminds obstetricians to consider the institutional and structural issues that are at work in their communities. After listing several decision-making strategies intended to guide counseling in rural and remote areas where transfer may be difficult, the bulletin cautions that "none of the principles, options, or pro-

TABLE 2. Evidence mentioned in ACOG guidelines

	Trial of labor after cesarean	Maternal-request cesarean delivery	Home birth
Perinatal outcomes			
Neonatal/perinatal death	X	X	X
Neonatal morbidity	X	X	
Maternal outcomes			
Short-term morbidity	X	X	X
Long-term morbidity	X	X	
Maternal death	X	X	X
Maternal-newborn dyad			
Breast feeding		X*	

* Mentioned under the heading of short-term maternal benefits.

cesses outlined here should be used by centers, health care providers, or insurers to avoid appropriate efforts to provide the recommended resources to make TOLAC as safe as possible for those who choose this option."[30]

Compare ACOG's support for *lowering* institutional and economic barriers to safe TOLAC with the organization's push to *erect* institutional and economic barriers to home birth. In 2008, the American Medical Association (AMA) voted to endorse ACOG's earlier policy statement that the safest place for birth was in the hospital, and tasked a subcommittee with drafting model legislation to that end.[31] This effort was widely interpreted among home birth practitioners as a foray by ACOG and the AMA into outlawing home birth. It may have been intended too to pre-empt moves to improve insurance coverage or ensure government payment for out-of-hospital births, in an era in which cost-effectiveness arguments carry increasing weight. In sum, comparison with the case of TOLAC indicates that the use of evidence to guide practice (and policy) on home birth is anomalous.

HOME BIRTH AS EXCEPTION: CHOOSING ETHICAL ACTIONS

The ways that ACOG draws on ethical principles to recommend action in the case of home birth are also anomalous, when compared to the organization's approaches to other controversial questions facing obstetrician-gynecologists. To understand what sorts of professional responses ACOG construes as ethical and unethical, we must first consider the range of actions that practitioners and institutions may take.

Treatment of Home Birth in Practice

The prevalence of home birth varies dramatically from state to state and community to community.[32] These variations probably reflect such factors as availability and legality of out-of-hospital birth attendants, coverage of home birth by insurers, and varying social and cultural perceptions of the desirability of home and hospital birth. Responses to home birth among hospital-based clinicians are also highly variable, both within and among communities.

A description of two places I know well—call them A and B—illustrates some of this contrast. A and B are points on a broader spectrum of response to home birth, neither at an extreme. Both are medium-sized university towns in states in which midwifery practice outside the hospital is legal. Both feature busy labor and delivery units at more than one hospital, and competition between the hospitals to attract pregnant women. Town A has certified nurse midwives (CNMs) who provide a substantial proportion of the obstetrical care at more than one hospital, and who participate extensively in the training of medical students, family medicine residents, and residents in obstetrics and gynecology. Town B's sole hospital-based CNM group appears more embattled. Its midwives are not integrated into the medical student or resident training programs. In both towns, a handful of out-of-hospital midwives attend home births; town B also has a freestanding birth center. In both towns, I know some physicians who believe that home birth is safe for carefully selected women and others who believe it is reckless and dangerous. The institutional patterns of response in the two places, however, have been quite different.

In town A, obstetricians decided decades ago that the persistence of home birth gave them reasons to make hospital transfer protocols and perinatal consultation networks seamless. A local perinatologist worked with community midwives to draft consultation and transfer arrangements that were later refined in practice. Despite personnel changes among the midwives and the doctors involved over the years, the university's perinatal team continues to provide backup and consultation for the local out-of-hospital midwives. Home birth midwives may send their clients in for screening visits with doctors in the obstetrics clinic. These women then return to their midwives, with the knowledge that a referral relationship is in place should it be wanted or needed later.

In town B, no formal relationship among obstetricians and home birth providers is in place. Obstetricians in one of the largest hospital practices say that they've been warned that anyone who backs up a home birth midwife will be fired from the practice. It is not uncommon in this community for physicians to refuse to provide continued antenatal care for a patient who plans a home birth; in many cases that means the patient's insurance cannot be used to help pay for routine antenatal labs, ultrasounds, or other indicated testing. Town B's out-of-hospital midwives cannot find a local obstetrician to evaluate their protocols or to review difficult cases or poor outcomes with them. In the absence of any formalized relationship, there are no smooth, rehearsed, stable protocols for transport or referral. Transports from out of hospital land with the on-call team, ensuring fragmented care and setting the stage for conflict.

In print, even the obstetricians who are most strongly opposed to home birth take pains to note that respectful and compassionate care for women transferred to the hospital after beginning labor at home is crucial—in part because fear of poor treatment at the hospital can contribute to unsafe delays in necessary transfers, with harmful consequences for mothers and their infants; and in part because compassionate and respectful care is always an ethical obligation. In practice, transfers can be punitive for birth attendants and for their patients, who may be upbraided for attempting delivery at home or left to linger in the emergency room for hours.[33]

Institutional responses and professional practices like these have ethical weight. Discontinuation of antenatal care for women choosing home birth; refusal to consult with, refer to, or review problem cases with home birth providers—at the very least, these actions seem likely to threaten the safety of pregnant women who do elect home birth. What do guidelines have to say about practices like these? In the case of the ACOG's home birth statement, nothing. Obstetricians would not discontinue antenatal care for a woman who continued to smoke or to drink alcohol during pregnancy. Such action would be considered an unethical patient abandonment, even though tobacco and alcohol use carry well-documented harm to the fetus, and tobacco use increases late fetal and neonatal deaths. In these cases, we consider that our patients' best interest requires us to stay involved. Why does a plan to give birth at home alter the ethical calculus so dramatically?

Treatment of Home Birth in Ethical Guidelines

On the grounds of women's autonomy, ACOG has strongly resisted legislative restrictions on reproductive choice, even when that resistance costs obstetricians politically or financially. The organization has consistently held that "respect for autonomy has particular importance in reproductive decision making, which involves private, personal, often pivotal decisions about sexuality and childbearing."[34] The guidelines summarized in table 3 show that the ACOG takes autonomy seriously. In its responses to other controversial practices—requests for TOLAC (discussed above), requests for pregnancy termination, requests for non-indicated surgeries including maternal-request cesarean section—ACOG considers structural and institutional factors that make autonomous choices possible. This is the second important way in which home birth is anomalous: in all cases but home birth, the simple provision of information is not thought to be enough. Respect for women's autonomous choices obliges physicians to additional action.

Termination of pregnancy is unquestionably far more dangerous to a fetus than is home birth. Yet ACOG reminds physicians who will not themselves provide abortions that they should provide safe and timely referrals to those who will, and in fact should consider locating their practices in communities that have abortion providers. "Those who choose the profession of medicine," notes the statement, "are bound by special *fiduciary duties*, which oblige physicians to act in good faith to protect patients' health—particularly to the extent that patients' health interests conflict with physicians' personal or self-interest."[35] Physicians' beliefs about the moral status of a fetus vary, ACOG acknowledges, but such beliefs "do not justify an erosion of clinicians' basic obligations to protect the safety of women who are, primarily and unarguably, their patients."[36] The statement also asks doctors to take care to distinguish issues of self-interest from those of conscience, given the controversy that surrounds abortion and the unpleasantness of the procedure. The key prin-

TABLE 3. Duties of obstetricians in the ACOG literature on selected controversies

	Pregnancy termination	Non-indicated surgery	Home birth*	TOLAC**
Must the OB/GYN perform/attend?	No	No	No	No
Must the OB/GYN refer/facilitate access?	Yes	Yes	No	Yes
Must the OB/GYN promote availability and safety in the community?	Yes	No mention	No	Yes

* While the committee opinion on home birth itself does not address these questions, a separate press release from the ACOG makes clear that the organization does not support individuals who attend home birth or who advocate for it. ACOG Office of Communications, "ACOG Statement on Home Births," news release, 6 January 2008

** Trial of labor after previous cesarian

ciple here seems to be that women's rights to privacy and bodily integrity outweigh their physicians' discomfort with, distaste for—*or even moral misgivings about*—the procedure.

Maternal-request cesarean section is also controversial in obstetrics. Like home birth, non-indicated cesarean requested by a pregnant patient represents a very small proportion of American births.[37] Like home birth, it has a symbolic importance well beyond the raw numbers. In a recently issued committee opinion,[38] ACOG outlined the available evidence on short- and long-term consequences of maternal-request cesarean for mother and newborn, considered psychosocial concerns and fears that might lead a woman to request a surgical delivery with no medical indication, and proposed restrictions on when and for whom non-indicated cesarean was reasonable. The committee cautioned that women's requests for cesarean should not be prompted by fears about intrapartum pain relief: obstetricians should ensure that support in labor, intrapartum anesthesia, and childbirth education should all be in place. The statement did not comment specifically on whether obstetricians could ethically refuse to provide surgery without a medical indication, nor whether they were obliged to refer patients who requested such surgery. Another committee opinion more broadly addressing "surgery and patient choice"[39] made clear that physicians were *not* obligated to provide procedures they considered to be unindicated or unproven, but concluded that if a patient brought up such a request and she and her physician could not reach an agreement on it, that the most appropriate course for the obstetrician was to provide a referral to another healthcare provider.

This comparison of recommendations again reveals the unique status of home birth. Guidelines on TOLAC, on pregnancy termination, and on non-indicated surgery all place women's autonomy in the foreground. They all propose that physicians who sincerely believe these procedures are harmful to women and their infants should still ensure access to these options by referral. They all discuss institution-level constraints on women's autonomous choices. For TOLAC and for pregnancy termination, obstetricians are reminded that they must also consider such constraints at the community level, and do their best to make sure safe and accessible care is available for women residing in their communities. *Only home birth is different.* The ACOG's statement on home birth does mention institutional issues, but raises them as if physicians had no part in creating and perpetuating them: women raising the topic of home birth "should be informed that . . . the availability of a certified nurse-midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical" to a safe home birth.[40] While physicians are obligated to *inform* women of these structural necessities for safe home birth, they are not asked at any point in the statement to *make them possible*. The contrast is striking.

By casting the provision of information about neonatal outcomes as not just the primary but the *sole* ethical responsibility of the obstetrician, the ACOG's home-birth statement obviates obstetricians' responsibilities to provide appropriate clinical care and to make the safest possible clinical environment for mothers and newborns. What, on its face, seems to be a statement of respect for women's autonomy, implicitly authorizes behaviors that unethically restrain truly autonomous choices. ACOG's fellows may refuse to consult with other professionals who offer home birth, may eject women electing home birth from their practice, may refuse to consider hospital privileges for even the most highly qualified physicians and nurse-midwives who attend births at home, and may block all efforts to get home-birth attendants educated, credentialed, regulated, integrated into health networks, or effectively peer reviewed. Practices like these, although they endanger women and their newborns, are not called out as unethical. They are instead tacitly approved.

WHY IS HOME BIRTH SO EXCEPTIONAL?

This review has argued (1) that similar evidence leads to strikingly different recommendations in the case of home birth and the case of TOLAC, and (2) that ACOG treats cases that appear to involve comparable ethical questions quite differently than it treats home birth. Why is home birth such an exception? Is this anomalous treatment solely about litigation risk? Is it about competition with midwives for market share, as some out-of-hospital birth advocates suggest? Is it about patriarchal control, as others suspect?

While these are not implausible explanations, both personal experience and review of the literature suggest to me that inadequately interrogated and strongly felt emotions are likely playing a role. Conversation gets very heated very fast when the topic of home birth arises in a roomful of obstetricians. Trolling for comments by doctors in online home birth forums will give one a sense of how inflamma-

tory the discussion can be. Researchers have found extremely strong responses to home birth among physicians. A team of sociologists, in interviews with doctors whom midwives had identified as friendly to low-technology births, found that even these select physicians "equate home birth with the direst of consequences—life threatening situations for babies and mothers, and they equate hospital birth with safety for babies and mothers."[41] Some of their interviewees referred to women who attempted home birth and their attendants as irresponsible, irrational, or idiots. A recent literature review concluded that obstetricians commonly claim that home birth is far more dangerous than the evidence suggests, characterize it as unspeakably reckless, and swap stories of home birth "train wrecks."[42] Signs of strong emotional responses to home birth appear in the material I reviewed while researching this article: the use of emotionally resonant anecdote as if it were evidence is striking, as is the often-contemptuous descriptions of women who elect home birth.

This tone of disdain is anomalous in the ACOG's literature. A 2008 press release from ACOG included this comment on women who chose home birth: "Childbirth decisions should not be dictated or influenced by what's fashionable, trendy, or the latest cause célèbre."[43] ACOG characterized such fashion-following mothers as selfish: their "main goal should be a healthy and safe outcome for both mother and baby. Choosing to deliver a baby at home, however, is to place the process of giving birth over the goal of having a healthy baby."[44] I have found no other statements by ACOG that take this tone, dismissive and patronizing at best, disdainful at worst, about our patients: not patients seeking non-indicated surgeries, not patients asking about currently fashionable and potentially dangerous cosmetic "vaginal rejuvenation," not patients using tobacco, alcohol, or narcotics that may cause serious fetal and neonatal harm—or death.

Contempt is not the only emotion at work. Some of the most negative responses to planned home birth suggest fear as an underlying issue when they cite frightening anecdotes as evidence. The Chervenak article concludes that "planned home birth does not meet current standards for patient safety in obstetrics, as illustrated by the recent preventable death from hemorrhage of an Australian midwife homebirth advocate while attempting delivery of her own child at home."[45] It seems unlikely that Chervenak and his colleagues would accept at face value a parallel statement, say, "planned hospital birth does not meet current standards for patient safety in obstetrics, as illustrated by the recent sepsis and quadruple amputation of a previously healthy laboring woman in a Florida hospital, or the recent fatal cardiopulmonary arrest of a laboring woman during epidural placement in Michigan."[46] Terrible and factual as these anecdotes are, they do not constitute the kind of epidemiological evidence needed to drive policy. The same article earlier appeals to clinicians to recall their own encounters with the devastating effects of delayed transport, an appeal guaranteed to bring unpleasant memories and elevated heart rates to readers—but not to bring clarity to the discussion at hand.

What are evocations of contempt and fear doing in the ostensibly scientific literature? Eliciting emotional responses is rhetorically potent. ACOG has asked its fellows to submit stories of their experiences with intrapartum or postpartum transfers of patients who had planned home birth.[47] These anonymous stories, not a product of valid sampling, not confirmed with chart reviews, and not arrayed against any comparison group, cannot serve as medical science. Were ACOG interested in assessing outcomes of home birth transfers systematically, the approach to data collection would have to be structured differently. But disaster stories *can* serve to claim clinical and moral authority.[48]

Might strong negative emotional responses to home birth—whether they spring from fear of being involved in "train wrecks," from grief over the birth-related tragedies we have experienced in our practice lives, or from anger at women who claim their own authority over birth, and reject ours—be distorting our professional ethics? As Martha Nussbaum has pointed out, the failure to interrogate one's emotional response to a situation or (especially) to a person can be ethically problematic. Emotions like disgust, grief, and fear can be clues that moral judgments are happening, Nussbaum argues. If we investigate them carefully, we may uncover unconscious biases that pervert ethical judgment.[49]

Most of the time, birth is amazing and wonderful. Sometimes it is terrible. In many years of work in hospitals inside and outside of the United States, I have seen women and their newborns die. Some died for want of obstetrical intervention, some despite it, and some because of it. Sometimes we just don't know why they died. Their deaths are seared on my memory in a way that the (much, much more common) beautiful births are not. I am sympathetic to those of my fellow obstetricians who—perhaps with similar deaths in mind—cannot bear to think about birth outside the range of our technologies. When that aversion leads us to dismiss those who

do choose home birth as reckless and selfish, and supports the institutional treatment of home birth attendants as pariahs, we close down an important conversation before it gets started. We may also endanger the very people we would protect.

CONCLUSION

What might happen if obstetricians stopped treating home birth as an anomaly and started treating it the way we do other controversial topics? What if we collectively recognized the problems with evidence in the case of home and hospital birth, interrogated and honestly acknowledged our own emotional responses to birth that happens outside our hands and our hospitals, and reconsidered our obligations to our patients—our patients as moral agents who, like us, are struggling to do the right thing? What if we took seriously, rather than dismissing contemptuously, the forces that drive women away from hospitals?

Home birth advocates could ethically argue that home birth should be safe, legal, and accessible to any appropriately low-risk woman who elects it. Home birth opponents could ethically work to make home birth rare: rare *not* because the evidence has been distorted to scare women, rare *not* because structural barriers have been erected to bar women from access to home births with skilled and safe providers, but rare because hospital birth has been re-envisioned with the laboring woman at its center. Those who oppose home birth and those who support it could agree that *to be safest*, home birth should be integrated into a system in which transfer and consultation are readily available, not feared, and never punitive. We could go a step further, and recognize that *to be safest*, hospital delivery should not mean giving up the possibility of a low-intervention, high-support, respectful and woman-centered birth—even for sick women.[50]

Clinicians who attend births in homes and hospitals could treat one another as colleagues and not as straw men. The naïve "birth works" proponent who believes birth to be inherently risk-free and who cannot recognize a disaster in progress, like the malevolent physician-automaton who sees in every birth the opportunity for lucrative and high-technology interventions on women's docile bodies, is a powerful rhetorical figure. How many of us know actual midwives or doctors who fit either stereotype? Surely if they exist at all they are vanishingly rare. (In my own practice lifetime, working with obstetricians and midwives in a range of contexts, I can think of only one candidate—decades ago.) Their persistence in our minds and our rhetoric contributes to a polarized discourse that does our patients a disservice.

If the only choice is to be afraid of birth in the hospital or to be afraid of birth at home, everyone loses: sick women, well women, families, newborns, and even obstetricians and midwives. This polarization can have especially tragic consequences at the interface between home and hospital, when necessary transfer is delayed too long, or when a home birth client who does get transferred is punished in the hospital for her "reckless" behavior. ACOG's treatment of home birth as something so frightening that it must be treated differently than all other reproductive choices contributes to a discourse that makes birth less safe, not more.

Obstetricians need not attend home births. One could argue that we should not, in fact. Most of us are probably not possessed of the patience or the many other skills necessary to attend home birth well: I know I am not. We are also much too expensive to be used in such time-consuming work as sitting through a long labor with a single woman. The provision of information that ACOG selects for us does not discharge our ethical obligations in reference to home birth, however, any more than it would in reference to pregnancy termination, to non-indicated cesarean section, or to trial of labor after cesarean. Comparison with those cases suggests that our ethical duties oblige us also to reflect and to act. We should examine the evidence with an understanding that the data will likely continue to be imperfect, and with careful attention to our own deep-seated emotions and the biases they may engender. To ensure our patients' safety and respect their autonomy, we should also refer women who desire home birth to the best providers who will offer it; continue respectful antenatal care when sought by those women choosing home birth; provide appropriate consultation to skilled home birth clinicians; and ensure that transfers are smooth and nonpunitive.

NOTES

1. M. MacDorman, T.J. Mathews, and E. Declercq, "Home births in the United States, 1990-2009," *National Center for Health Statistics Data Brief No. 84*, (Hyattsville, Md.: National Center for Health Statistics, 2012).

2. W. Kline, "Birth in transition: modern midwifery and the controversy over home birth," paper presented at Medical History and Bioethics Colloquium, University of Wisconsin-Madison, 2 November 2012.

3. W.H. Pearse, "The home birth crisis," *Bulletin of the American College of Obstetricians and Gynecologists*, July 1977.

4. MacDorman, Mathews, and Declercq, see note 1 above.

5. "ACOG Committee Opinion No. 476: Planned home birth," *Obstetrics & Gynecology* 117 (2011): 425-80.

6. Ibid., 425.

7. Ibid., 425 and 427.

8. Royal College of Obstetrics and Gynaecology / Royal College of Midwives, "Joint Statement No. 2 April 2007," *http://www.rcog.org.uk/womens-health/clinical-guidance/home-births,* accessed 17 December 2012.

9. L.A. Plante, "Mommy, what did you do in the industrial revolution? Meditations on the rising cesarean rate," *International Journal of Feminist Approaches to Bioethics* 2, no.1 (2009): 140-7, 140..

10. F.A. Chervenak, L.B. McCullough, and B. Arabin, "Obstetric ethics: an essential dimension of planned home birth," *American Journal of Obstetrics & Gynecology* 117 (2011): 1183-7.

11. Ibid., 1184.

12. F. Chervenak et al, "Planned home birth: the professional responsibility response," *American Journal of Obstetrics & Gynecology* 208, no. 1 (January 2013): 31-8.

13. Ibid., 3-4. Exactly what to "do so" covers here is unclear, even though the consequences of "doing so" are to be dire. Whether that vagueness is an accident of bad writing or an attempt to be maximally threatening to home birth advocates is not clear. The article displays a similar lack of clarity in defining what exactly "the professional responsibility approach" to ethics is, and whether it differs from a paternalism that understands pregnant women not as moral agents, but as fetal containers.

14. For an overview of this research, see H. Lambert and E.A. Bogdan-Lovis, "Introduction: Gift horse or trojan horse: social science perspectives on evidence-based health care," *Social Science & Medicine* 62 (2006): 2613-20.

15. R.G. DeVries, "The warp of evidence-based medicine: lessons from Dutch maternity care," *International Journal of Health Services* 34 (2004): 595-623, 617.

16. Ibid., 619. Evidence on home birth in the U.S. fits this pattern of rhetorical justification. As each new home birth study appears, it is torn apart by detractors and promoted as definitive by supporters. Once one is aware of the key players involved, the positions taken are mostly predictable.

17. J.P. Rooks, "Evidence-based practice and its application to childbirth care for low-risk women," *Journal of Nurse Midwifery* 44 (1999): 355-69.

18. See O. Olsen and J.A. Clausen, "Planned hospital birth versus planned home birth," *Cochrane Database of Systematic Reviews* issue 9 (2012).

19. J.R. Wax et al., "Maternal and newborn outcomes in planned home birth vs planned hospital births: a metaanalysis." *American Journal of Obstetrics & Gynecology* 2010;203:243.e1-8.

20. See, e.g., M.J.N.C. Keirse, "Home birth: gone away, gone astray, and here to stay," *Birth* 37 (2010): 341-6.

21. P.A. Janssen et al., "Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician," *Canadian Medical Association Journal* 181 (2009): 377-83; E.K. Hutton, A.H. Reitsma, and K. Kaufman, "Outcomes associated with planned home and planned hospital births in low-risk women attended by midwives in Ontario, Canada, 2003-2006: A retrospective cohort study," *Birth* 36 (2009): 180-9.

22. P.E. Klassen, "Sacred maternities and postbiomedical bodies: Religion and nature in contemporary home birth," *Signs: Journal of Women in Culture and Society* 26 (2001): 775-809; R. Davis-Floyd,"The technocratic body: American childbirth as cultural expression," *Social Science & Medicine* 38 (1994): 1125-40.

23. G. Chamberlain, A. Wraight, and P. Crowley, *Home Births: The Report of the 1994 Confidential Enquiry by the National Birthday Trust Fund* (New York: Parthenon Publishing, 1997).

24. "ACOG Committee Opinion #361: Breastfeeding: maternal and infant aspects," *Obstetrics & Gynecology* 109 (2007): 479-80.

25. C.Y. Spong et al., "Preventing the first cesarean delivery: Summary of a joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop," *Obstetrics & Gynecology* 120 (2012): 1181-93.

26. "ACOG Practice Bulletin #115: Vaginal Birth After Previous Cesarean Delivery," *Obstetrics & Gynecology* 116 (2010): 450-63.

27. "National Institutes of Health Consensus Development Conference Statement: Vaginal Birth After Cesarean: New Insights. March 8-10, 2010," *Obstetrics & Gynecology* 115 (2010): 1279-95.

28. The NIH statement cited above provides a neonatal mortality rate (death in first 28 days of life) of 1.1 per 1,000 for trial of labor and 0.5 per 1,000 for elective repeat cesarean. Perinatal mortality (death between 20 weeks gestation and 28 days of life) is 1.3 per 1,000 for TOLAC, compared to 0.5 per 1,000 for elective repeat cesarean. See note 27 above, p. 1286.

29. "ACOG Practice Bulletin #115," see note 26 above, p. 457.

30. Ibid.

31. The original resolution is available for download at *http://elephantcircle.net/wp-content/uploads/2011/01/AMA-Resolution-205.pdf,* accessed 14 December 2012. A brief discussion of the resolution and response from the perspective of a health law expert is available at *http://lawprofessors.typepad.com/healthlawprof_blog/2008/06/ama—home-birt.html,* accessed 14 December 2012.

32. See note 1 above.

33. R.E. Davis-Floyd, "Home Birth Emergencies in the United States: The Trouble with Transport," in *Unhealthy Health Policy: A Critical Anthropological Examination*, ed. A Castro and M. Singer (New York: Alta Mira Press, 2004).

34. "ACOG Committee Opinion #385: The limits of conscientious refusal in reproductive medicine," *Obstetrics & Gynecology* 110 (2007): 1203-8.

35. Ibid., 1205.

36. Ibid., 1205.

37. Earlier estimates suggesting that cesarean section

on maternal request accounted for 2.5 percent of all American births are now thought to be substantially too high, artifacts of working from hospital billing data. A large nationally representative study suggests a rate of about 1 percent: see, E.R. Declercq et al., *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences* (New York: Childbirth Connection, 2006).

38. "ACOG Committee Opinion #559: Cesarean delivery on maternal request," *Obstetrics & Gynecology* 121 (2013): 904-7.

39. "ACOG Committee Opinion #395: Surgery and patient choice," *Obstetrics & Gynecology* 111 (2008): 243-7.

40. "ACOG Committee Opinion No. 476," see note 5 above, p. 425.

41. W. Simonds, B.K. Rothman, and B.M. Norman, *Laboring On: Birth in Transition in the United States* (New York: Routledge, 2007), 240.

42. R.A.S. Freeze, "Attitudes towards home birth in the USA," *Expert Reviews in Obstetrics and Gynecology* 5, no. 3 (2010): 283-99.

43. ACOG Office of Communications, "ACOG Statement on Home Births," news release, 6 January 2008.

44. Ibid.

45. Chervenak et al., 2013, see note 12 above, p. 5.

46. R. Stutzman, "Sanford woman settles lawsuit in flesh-eating bacteria case," *Orlando Sentinel,* 18 May 2009; M. Yoshida, H. Matsuda, I. Fukuda, and K. Furuya, "Sudden cardiac arrest during cesarian section due to epifual anaesthesia using ropivacaine: a case report," *Archives of Gynecology and Obstetrics* 277, no. 1 (2008): 91-4.

47. The author, an ACOG fellow, received emailed solicitations for stories of unsuccessful home birth attempts from the state and national organizations.

48. P.A. Kaufert, J. O'Neil, "Analysis of a dialogue on risks in childbirth: Clinicians, epidemiologists, and Inuit women," in *Knowledge, Power & Practice: The Anthropology of Medicine and Everyday Life*, ed. S. Lindenbaum and M. Lock (Berkeley, Calif.: University of California Press, 1993).

49. M. Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (New York: Cambridge University Press, 2001).

50. A.D. Lyerly, "Ethics and 'normal birth,' " *Birth* 39, no. 4 (2012): 3515-7.