

Judith A. Lothian, "Being Safe: Making the Decision to Have a Planned Home Birth in the United States," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 266-75.

Being Safe: Making the Decision to Have a Planned Home Birth in the United States

Judith A. Lothian

ABSTRACT

Although there is evidence that supports the safety of planned home birth for healthy women, less than 1 percent of women in the United States choose to have their baby at home. An ethnographic study of the experience of planned home birth provided rich descriptions of women's experiences planning, preparing for, and having a home birth. This article describes findings related to how women make the decision to have a planned home birth. For these women, *being safe* emerged as central in making the decision. For them, *being safe* included four factors: avoiding technological birth interventions, knowing the midwife and the midwife knowing them, feeling comfortable and protected at home, and knowing that backup hospital medical care was accessible if needed.

INTRODUCTION

Although there is no evidence that hospital birth is safer than planned home birth for healthy, low-risk pregnant women,¹ and there are an increasing

number of well-designed observational studies that support the safety of planned home birth for healthy women,² less than 1 percent of women in the U.S. plan a home birth.³ There is increased interest in home birth in the U.S., as reflected in a small but significant increase in planned home birth.⁴ How do women in the U.S. make the decision to have a planned home birth? As part of a larger ethnographic study of the experience of planned home birth for women and their midwives, women described their experience of making the decision to have a planned home birth. This article presents these findings.

BACKGROUND

High quality observational studies suggest that for healthy, low-risk women, home birth is a safe alternative to planned hospital birth.⁵ When compared to hospital birth, for planned home birth there are fewer interventions, no cesareans, and similar outcomes for mothers and babies.⁶ Most of these studies were done in countries where, unlike the U.S., home birth is well integrated into the maternity care system. Of these studies, only three were conducted in North America.⁷ The North American studies suggest no differences in outcomes for mother or baby when compared with hospital birth, but there were significantly fewer interventions in

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the planned home birth groups. A study by the Birthplace in England Collaborative Study Group found that, in the planned home birth group, there was a small but significant increase in risk for first-time mothers, although the risk was extremely low for both first and subsequent births.⁸ In contrast, a large cohort study in the Netherlands found that first-time mothers were not more likely to experience complications, and that there were fewer maternal complications in all women giving birth at home, compared to those giving birth in the hospital.⁹ A meta-analysis of home birth by Wax and colleagues identified fewer interventions with similar outcomes for mothers and babies, as well as less incidence of prematurity and low-birth-weight infants in the home birth group, compared to the hospital group.¹⁰ The Wax study found an increase in risk of neonatal mortality for home birth compared to hospital birth; however, the largest study included in the meta-analysis did not differentiate between planned and unplanned home birth.¹¹ This could account for the finding of a small but significant increased risk of neonatal mortality in the home birth group.

The American Congress of Obstetricians and Gynecologists (ACOG) traditionally has opposed planned home birth, although its latest statement, a committee opinion on planned home birth, notes support for women's right to choose a birth setting, including the home.¹² Most recently, in a commentary on the ACOG committee opinion on planned home birth, obstetricians were advised to provide women who express an interest in home birth with evidence-based recommendations against it, to refuse to participate in home birth, and to not take part in any randomized control trials of home birth.¹³ Suggesting that there is evidence that recommends against planned home birth for healthy, low-risk women reflects the ongoing opposition of the ACOG to planned home birth, rather than the growing body of research that supports the safety of home birth for some women.¹⁴

The home birth debate is taking place amidst increasing concern with the rising cesarean rate and intervention-intensive maternity care in the U.S. Two documents, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, and "2020 Vision for a High-Quality, High-Value Maternity Care System," highlight problems with the current maternity care system and suggest possible solutions.¹⁵ Consumer advocacy efforts reflected in the documentary film *The Business of Being Born*, and in journalist Jennifer Block's *Pushed: The Painful Truth about Childbirth and Modern Maternity Care*, have received media attention, raising awareness of prob-

lems with the current U.S. maternity care; they challenge the current maternity care system and argue for the safety of planned home birth.¹⁶

The 2011 Home Birth Consensus Summit examined the status of planned home birth in the larger context of U.S. maternity care.¹⁷ Stakeholders, including midwives, nurses, childbirth educators, doulas (labor support professionals), childbearing women, obstetricians, pediatricians, lawyers, insurance providers, and lobbyists met over a three-day period and ultimately developed nine common ground statements. One of those statements affirmed stakeholders' commitment to women's right to make an informed decision, free of pressure, coercion, or punishment, about the birth setting.

There is little research examining how women go about making such an important decision. How do women in the U.S. make the decision to have a planned home birth within the context of the current U.S. maternity care system and the controversies that swirl around it?

METHODOLOGY

Qualitative research aims to describe the lived experience of study participants, to understand the world from their point of view.¹⁸ The aim of this ethnographic study was to describe the experience of home birth in the U.S., including the decision to have a planned home birth. Informal interviews and participant observation were used to obtain rich descriptions of women's experiences choosing, planning, and then having a home birth. In our initial meeting, I asked each woman to share how she came to the decision to have a planned home birth. Over the course of our months together, the women then elaborated on their decision to have a planned home birth.

Researchers' Stances

In qualitative research, it is essential to present the lens through which the researcher views the world, specifically what values, biases, and assumptions might influence what is observed and heard and how this information is then interpreted.¹⁹ This is important because it helps the reader to judge the credibility of the findings.

For several decades I have advocated for normal physiologic birth and women's right to make autonomous decisions related to giving birth. My interest in home birth emerged out of concern for the increasing medicalization of childbirth in the U.S. and related restrictions on women's childbirth choices, including the choice of birth setting. I have

written about home birth as a possible way to protect and support normal, physiologic birth. However, when I began the study, I had been present at only one home birth, the birth of a granddaughter. I had no knowledge of the experience of home birth for women, including how women, other than my daughter, come to the decision to have a planned home birth.

To reduce the chance that my values and beliefs would unduly influence either data collection or analysis, I kept a journal, and during my time with the women in this study I constantly reminded myself to listen carefully, to not make judgments, and to keep my views, as much as possible, to myself. I asked myself, "How are my beliefs influencing what I hear, observe, and interpret what I hear and see?" The findings of this study reflect my ongoing efforts to reduce bias.

Recruitment

Women learned of the study from their home birth midwife and those interested in participating contacted me directly. The eligibility requirement was that the woman was planning a home birth. I met the women only after they had made that decision.

Ethical Considerations

The research design was reviewed and approved by the Institutional Review Board at Seton Hall University. The women were assured that their names would not be used and no one would be able to connect them to the findings. Specific permission was obtained for audio-recording the interviews. The women were assured of confidentiality and reminded that they could withdraw from the study at any time. None of the participants did so.

As a way to equalize the power in our relationship, I met the women in their home. I reminded the women over and over that I was learning from them, that they were the experts. These strategies increased women's trust and ultimately the quality of the data.

The research was supported by a Seton Hall University Research Council Grant.

Data Collection

For this ethnographic study I informally interviewed and observed 13 women during their pregnancy and after the birth of their baby. The informal interviews typically lasted two to three hours. Often their husband, their other children, and occasionally their mother were present. Each woman participated in informal interviews at least twice and

as many as four times. I was also a participant observer at prenatal and postpartum midwifery visits and for some of the births.

As part of the larger study, one of my first questions was, "How did you decide to have a planned home birth?" Although this discussion was a significant part of the first visit, over the course of my time with the women they kept coming back to it, adding additional insight about their decision.

Interviews were audio-recorded and transcribed. Observations were carefully recorded soon after each meeting. I added participants until data saturation was reached and no new information was being learned.

Data Analysis

The data were analyzed using standard qualitative techniques—developing codes, categories, and themes.²⁰ To insure trustworthiness of both the data and the analysis, I followed Lincoln and Guba's guidelines.²¹ Prolonged engagement and persistent observation, essentially spending long periods of time with the participants, increased the trustworthiness of the data; I met with the women over a period of several months, and each meeting lasted several hours. Lincoln and Guba describe using multiple types of data (triangulation of data) to enhance trustworthiness: I was a participant observer in addition to participating in informal interviews. Member checking also enhances trustworthiness. I regularly asked the women, "Am I getting this right?" or "Is this what you mean?" At the completion of the study, I checked back with the women and each assured me that the findings accurately reflected her experience. I kept an audit trail in which methodological and analytic decisions were carefully recorded. All of these activities contribute to the trustworthiness of the research and insure that the findings are "worth paying attention to."²²

THE WOMEN: A SNAPSHOT

Seven of the women were experienced mothers. Two of these women had a previous home birth, and three women had a birthing center birth with a midwife. One woman had a prior cesarean and one woman had a traumatic hospital birth experience. Six of the women were expecting their first baby, and all but one of these women began the pregnancy under the care of an obstetrician.

Of the 13 women, 11 were Caucasian and two were Hispanic. One woman was French and had recently moved to the U.S. One woman was English and had lived in the U.S. for a number of years. All

of the women were married or had a partner. All of the women lived in a very large city in the northeast U.S. Their care was provided by five different certified nurse midwives (CNMs). One of the home birth midwives also assisted hospital births. The women were actresses (three), teachers (two), artists (two), writer (one), PhD student in sociology (one), nurse-midwife (one), and doulas and childbirth educators (three).

The women described themselves as “usually pretty mainstream,” “not hippy dippy at all,” and “I couldn’t be less crunchy granola.” One woman said, “I wanted to be able to do the normal, mainstream thing but it just wasn’t happening.” One of the doulas shared, “Before I was a doula I would have thought having a home birth was insane.” All of the women had a mother who had a “natural birth,” and two of them had a home birth (one in England, the other in France). The women shared that their mother told positive birth stories through their childhood. One woman said, “My mother always talks about birth being an amazing experience.”

Unlike many, if not most women, these women were not fearful of birth, nor particularly concerned with pain. One woman said, “We’ve been programmed to be fearful and scared, but I say bring it on. Since when do I have to be afraid of pain?” Two women who had given birth before had negative experiences, of varying degree, with obstetricians, nurses, and hospitals. These women made the decision to have a planned home birth early in pregnancy and had thought about it before becoming pregnant. One of these women had trained as a doula and childbirth educator after her traumatic first birth experience as a way to help other women. Two women had a previous home birth and three women had a previous birthing center birth, one in a free-standing birthing center and two at a hospital based birthing center. Each of these women was confident that a planned home birth would be even more satisfying than their birth center birth, and they looked forward to the midwife coming to them instead of having to go to the midwife.

Five of the six women expecting a first baby confirmed the pregnancy with a gynecologist and initially intended to have standard maternity care. Their negative experiences early in pregnancy were pivotal in looking at other options.

One woman expecting her first baby changed from an obstetrician to a home birth midwife early in the first trimester after becoming dissatisfied with her obstetrician. The four other women made a decision between 18 and 24 weeks, several after changing obstetricians first and being equally dissatisfied.

SETTING THE STAGE

Three themes emerged that set the stage for making the decision to have a planned home birth: “I want a natural birth,” “I am increasingly worried about interventions,” “I want to know who is taking care of me, and equally I want them to know me.”

“I Want a Natural Birth”

All of the women were brought up with a positive birth story, and this probably contributed to their wanting a natural birth. All of the women described what they meant by natural birth in several ways: “letting labor and birth happen with no medical interventions,” “the way nature designed birth to be,” “no medication,” “going into labor on my own.” Four of the women had extensive knowledge and experience with birth. All of the women expressed the belief that “Pregnancy is not an illness. My body was created to give birth.” One woman said, “I mean women have been doing this from the beginning of time.”

The women were not naïve about the pain of childbirth, but were not fearful and believed they could manage the pain. One woman said, “I want to see how I do with it. This is the best pain.” Another said, “I’m thirsty for going through the experience.” This statement captured every woman’s excited and confident anticipation of her labor and birth.

“I Am Increasingly Worried about Interventions”

All of the women were worried about intervention-intensive labor and birth in the hospital. They were all concerned with the rising cesarean rate. They believed that the likelihood of those interventions endangered their ability to have a natural birth. The following quotes provide some insight into the women’s experiences and reactions.

One woman shared, “So I asked [my obstetrician] about epidurals and she looked at me and said, ‘You’d have novocaine for a root canal wouldn’t you?’ I thought, “She doesn’t get that this is bringing a new life into the world.” Another woman said, “Every time I set foot in the doctor’s office I worried about something being wrong.” Others said, “I don’t want to go into labor thinking of the odds.” “Why am I having all those tests done? It makes no sense.” “Why are you messing with me? Why are you putting stuff in my body to make things go faster? My body knows how to give birth.” “We talked about pitocin and epidurals. I felt like she would do what she wanted. It made me feel nervous.”

It is important to note that these women wanted information and were extremely knowledgeable

about pregnancy and childbirth. What they did not want was care that was focused on risks, or that involved the routine use of interventions. They did not want prenatal care that expects trouble.

Most of the women had seen the documentary *The Business of Being Born (BOBB)*,²³ and this confirmed their fears about obstetric interventions. One woman summed it up: “We watched the *BOBB* and I was horrified at the idea of being in a hospital. It scared me.” Another woman said, related to her initial plans to use an obstetrician and go to a hospital, “This all feels so uncomfortable, so wrong, so unsafe.” One woman was exploring the option of changing obstetricians and hospitals and went on a hospital tour. “So, I went on a hospital tour and I said to myself ‘I don’t feel safe here,’ anyone can come in and out and I’m not in control.”

The women were not just concerned with routine intervention during labor and birth. They knew that one intervention could lead to another and that a cascade of interventions could lead to a cesarean.²⁴ They all described routine interventions as increasing risk for themselves and for their baby.

The women also talked about not having control in the hospital, and not being able to have choices in the hospital. They believed that routine interventions and the cascade of interventions would keep them from being able to do what they needed to do to have a natural birth. One woman said, “I began to realize that the chances of me having a natural birth in the hospital were slim.”

“I Want to Know Who Is Taking Care of Me, and Equally I Want Them to Know Me”

For most of the women, negative experiences with obstetricians and hospitals helped shape their desire for being cared for by someone who knew them and who respected their choices. Several of the women’s stories sum up the women’s experiences in early pregnancy at obstetrician visits: “The last visit she came in and sat at the desk and looked at the computer and she had her back to me. The only time she looked at me was when she got up to leave. I thought, ‘I’m not coming back.’ ” “It was clear she was really rushed and had no interest in any sort of ‘me’ issue, just make sure the baby is alive and the blood pressure is ok and get me out of the office.”

The women shared these thoughts about the maternity care they had experienced: “I always felt bad, like these guys don’t care if I’m here or not. No personal attention or concern.” “You’re on a conveyor belt. That doesn’t feel safe.” “They never spoke to me like a person.”

One woman said, “I consider myself independent, a tough lady, but in those offices I, like I lose all my power. I want to cry instead of standing up and saying I don’t want you to do that to me.”

For these women, the obstetricians’ behaviors conveyed a lack of respect, and a lack of caring about each woman’s unique and special experience of pregnancy and birth. The women in this study wanted a careprovider who knew them, respected them, and cared about their experience. The women also believed that the outcome of respect for them would be a willingness to let them make decisions. Several women’s words sum up what they wanted: “I want to know who will be with me.” “I want to know my midwife well enough to trust her.” “I want to make my own decisions.” When the women talked about making their own decisions, it was always in the context of the supportive, collaborative, and trusting relationship they had with their midwife. It is also important to note that these women were extremely knowledgeable about childbirth and evidence-based maternity care.

MAKING THE DECISION: A MULTI-STEP PROCESS

Once the women realized that what they wanted would most likely not be possible in a hospital with an obstetrician, they began to do extensive research to understand their options. Making the decision to have a planned home birth involved a complex, multi-step process: learning more about birth and home birth, finding a home birth midwife, resolving doubts, and then protecting their decision.

Learning about Birth and Home Birth

The decision to have a planned home birth involved methodical searching for information, and talking to those knowledgeable about birth choices. From the beginning of pregnancy, the women read and visited internet sites to learn about birth. For the women who started out on a traditional path, the reality of their early experiences with obstetricians and hospitals motivated them to look into home birth. Three women who had given birth with a midwife either in the hospital or at a birthing center also did extensive research related to home birth.

The women read a wide variety of pregnancy and childbirth books and were drawn to the books that championed natural birth, like *Ina May’s Guide to Childbirth*²⁵ and *The Official Lamaze Guide: Giving Birth with Confidence*.²⁶ One woman read 17 books and said, “I feel more prepared for birthing than I ever felt for anything.” Many of the women

toured hospitals and birthing centers and saw *The Business of Being Born*.

Most of the women knew other women who had given birth at home, although they had not spoken to these women about the experience until they began considering having a planned home birth. One woman's husband was born at home and one woman had a cousin, a nurse, who had a home birth. Once they started seriously considering home birth, they searched the internet and reached out to blogs and websites about home birth. Several women went to information nights sponsored by a birth advocacy organization, and had the opportunity to speak with women who had had a planned home birth.

While still considering a hospital birth, several of the women interviewed a doula. The doulas were an important source of information for these women. One doula shared, "From what you say you want in labor it seems to me that you might consider a planned home birth." After doing some reading early in pregnancy, one woman said, "From everything we've read, what happens in the hospital just doesn't make sense. Like being on your back to push."

Finding a Midwife

Once the women decided that planned home birth might be an option, they searched websites and blogs and spoke with other women about finding a midwife. Finding a home birth midwife in many ways "sealed the deal." All of the women interviewed at least two midwives, with the exception of the woman who was a midwife herself. She had made a decision about her home birth midwife while still a student midwife. Husbands were actively involved in the decision making, although all of the men deferred to their wife for the final decision. The husbands were present at the initial interviews and supported both the decision to have a planned home birth and the choice of midwife.

The interviews included a discussion of prenatal care, as well as the birth. All of the women appreciated that prenatal care would be provided at home. One woman said, "The home birth is bigger than where my baby will be born. It is about the kind of care that I get."

According to all of the women, in a long interview with their midwife (at least two hours as compared to a typical obstetrician visit of 15 minutes), they began the process of getting to know each other. They were not rushed. The midwife listened carefully to what they wanted and to their concerns.

All of the women communicated that they "clicked" with the midwife they chose. One woman said, "When I met her it just felt right. She's down

to earth but not crunchy." Another said, "She has a warmth, a slowness, so I thought 'She's the one.'" And another woman shared, "She answered our questions in language we could understand, very straightforward."

The women did not want their midwife to be indifferent or to take their experience for granted. One woman said, "The midwife is as excited as we are," and another woman said, "She loves what she does and it shows."

Women questioned the midwives about their level of experience and about risks and "what ifs." The husbands were especially concerned about this. One woman said, "I asked her 'what if' . . . and she knows just what to do." Another woman said, "She told us all the emergency equipment she brings to every birth and that made us feel better." And another woman said, "She was a good combination of super experience, like years in the ER [emergency room]. I feel safe with her and she is so down to earth." One husband said, "Just because she [the midwife] doesn't operate like a doctor doesn't mean she doesn't know things . . . she is extremely knowledgeable."

Resolving Doubts

All of the women, with the exception of the midwife and one doula/childbirth educator, had doubts initially about home birth, and this popped up intermittently for the women over the course of their pregnancy. Safety was important to these women. They were well aware that childbirth might entail possible risks for them and their baby. All of the women acknowledged that complications might occur. One of the women knew someone who had lost her baby during a home birth and also knew several women who had been transferred to the hospital during labor.

Reading and talking to other women helped resolve their doubts. Talking with their midwife, initially and then at each prenatal visit, also helped the women resolve lingering doubts. The women knew they were healthy and low risk, and so met the criteria for a planned home birth. Their concerns were about problems arising during the labor and birth. Many of the women specifically questioned their midwife about different scenarios. What if I can't bear the pain? What if I go into labor preterm? The midwives answered their questions and reassured them by clearly explaining what they would do, including, if necessary, bringing them to the hospital. One husband, an EMT [emergency medical technician] himself, said, "Our midwife has all the emergency equipment EMTs have." One of the

woman said, "I asked my midwife, 'what if,' and she said, if that happens we will deal with it." Another woman said, "She is always so reassuring but I trust that if there is anything to worry about she'd let me know that too."

All of the women lived within a mile of a hospital and most were close to a major medical center. Several women noted that "women have a misconception that if you need medical attention in a hospital you won't get it."

Protecting the Decision

Once the decision was made, all of the women were careful about whom to tell about their decision to have a planned home birth. Most of the women said that once the decision was made, they did not want to be challenged. Another shared that she wanted to protect herself from "bad energy." All of the women discussed whom they shared their decision with and whom they did not. One woman summed up what all of the women actually did: "We don't tell anyone who will give us a hard time about our decision . . . we just get a sense from people."

Some of the women had family members who were persuaded to think differently and came to support the decision wholeheartedly. One father who was born at home himself was doubtful at first. He and his wife watched *The Business of Being Born* and changed their minds. One husband's father was a physician. After talking with his son and daughter-in-law he said, "I think you have made the best decision for yourselves." One husband told his mother, who was concerned about the decision, "It's not your decision. We know more than you do. It is closed for discussion." One woman said, "I didn't tell half my siblings. They'd just worry. And give me grief." The need to protect the decision was in many ways a response to the societal belief that the hospital is the safest place to have a baby and that an obstetrician provides safer care than a midwife.

Over the course of their pregnancy, the women became increasingly sure of and pleased with their decision and confident in their ability to give birth. One woman said, "Birth is as safe as life gets." She elaborated that life involves risk that we try to reduce, but can never eliminate entirely, and that birth is no different. Another woman said, "A friend told me I must be so brave to have a home birth. I told her it's going to the hospital that requires bravery."

BEING SAFE

The meta-theme that emerged and that captured the essence of these women's decision to have a

planned home birth was *being safe*. *Being safe* for these women included: avoiding routine interventions, knowing the midwife and the midwife knowing them, feeling comfortable and protected at home, and knowing that hospital medical care was available if needed. These women did not have a naïve or unrealistic view of risk. The factors they associated with being safe were evidence based and associated with reducing risk and enhancing safety for healthy women.²⁷

Avoiding Interventions

All of the women viewed routine medical interventions as increasing risk for herself and for her baby. One woman articulated it this way: "That's the thing about the safety of the hospital. I didn't want those things that could lead to the domino effect." The women were concerned about cesarean and epidurals: "Women don't see cesarean as being unsafe. I do." And, "I'm not comfortable with the risk of an epidural." Another woman said, "At home I avoid all the hospital issues. Like them taking my baby to the nursery and giving formula."

In fact, the concerns the women expressed about intervention-intensive maternity care reflected a knowledge of evidence-based maternity care. They knew that it was safer for mother and baby to be together from the moment of birth. They knew that the epidural had unintended effects on labor, prolonging labor and increasing the risk of requiring an instrument delivery, and that the medications used in the epidural affect the baby. They knew that inducing labor disrupts the process of labor and increases the risk of needing a cesarean. They knew that cesareans were not without risk for themselves and their baby.²⁸ Because they were knowledgeable about the effects of interventions, all of the women believed that "The risk factors are just less at home."

"I Want to Know the Midwife and I Want the Midwife to Know Me"

Knowing the midwife and the midwife knowing them was important to these women. Right from the interview visit, all of the women reported that, when the midwife came, "It's all about me and my world." All of the women described their midwives similarly: "She listens. I can call her anytime." "I never worry that I am bothering her." "It's the encouragement. I know I'm getting her and that's it. I like that she is going to be the one and I know her." "She's always so reassuring." "We sit down and she lets me start to talk and that is the springboard for discussion. It's like a conversation and that's what I like." "It's so relaxing to be with her."

Out of this interaction, the women and midwives got to know each other, and, in doing so, developed a mutual respect that encouraged the women's autonomy. One woman's comment about testing was typical: "Testing? We talk and she says do what you want, it's entirely up to you." "It's wonderful to have freedom and respect." At the same time, the women had a deep respect for the midwives' knowledge.

Research suggests that women share concerns and information more honestly when there is mutual respect and a nonjudgmental approach.²⁹ This was certainly true for the women in this study. One husband said, "It's easy to be vulnerable at home. To express concerns. To talk about things you wouldn't in a doctor's office. With someone you know and who knows you."

The women in this study believed that knowing each other well and the mutual trust that developed enhanced safety.

Feeling Comfortable and Protected at Home

These women agreed that "I feel like I can do what I have to do and do it better at home." They understood both the process of normal physiologic birth and its challenges. They also understood what would help them in labor. The women agreed that at home, "I can do what I want. I'm in charge at home," and "There are no rules at home." The women knew they could eat and drink, move freely, use a birthing pool, and that "Everyone at the birth will be someone I want to touch me and encourage me." The women also identified that being at home allowed them to be protected from negative people. The women shared, "I don't feel like justifying my wishes and decisions to dozens of different people." The women had heard stories from women who wanted to walk in labor, wanted several support people, or wanted a water birth, and were either told they couldn't do it, or were pressured by nurses or physicians to "follow the hospital rules." These women were relieved to not have to fight to have the kind of labor and birth they wanted.

In summary, the women expressed, "I feel safe and protected at home." The privacy, freedom to move and find comfort in a wide variety of ways, and the excellent labor support that women had in their own home facilitated the normal physiologic process of birth and reduced the risk of needing interventions, thus enhancing safety.³⁰

Knowing that Hospital Medical Care Is Available, If Needed

Right from the beginning and over the course of the pregnancy, the women developed an understand-

ing of how and when their midwife would provide medical care. They knew that their midwife was knowledgeable, skilled, and experienced. They knew that the midwife brought equipment to handle emergencies to every birth. They knew that if complications arose that required hospital medical care, that it was available, and they would be transferred. One woman said, "I know if the pain gets too brutal I can go to the hospital." Another woman said, when discussing the possibility of complications, "The hospital is only two blocks away." One husband said, "We have a backup plan. We're not waiting until the last minute. If there's a problem, we're going to know and we'll address it immediately." The women also trusted the midwife's clinical judgment. "If she says we need to go to the hospital I will trust her completely."

DISCUSSION

The findings of this study are consistent with survey findings from the United Kingdom, the Netherlands, Australia, Sweden, and Canada and qualitative research done in the U.S. that describe women's reasons for choosing a planned home birth.³¹ These studies identified that women who choose home birth want to avoid unnecessary interventions, have a relationship with their careprovider, make decisions for themselves, and have control over the birth environment. Many of the women in these studies also reported negative experiences with careproviders and hospitals. The findings of this study do not support the belief that women do not carefully consider risk or that they make the decision to have a planned home birth for selfish reasons.³² The women in this study carefully considered their options and chose home birth specifically to increase safety for themselves and their baby.

Compared to previous research, this research provides a deeper understanding of both the process of making the decision to have a planned home birth and women's evidence-based understanding of safety. These women believed that safety was enhanced by avoiding interventions, feeling secure and comfortable in their own home, knowing the midwife and the midwife knowing them, and knowing that medical care was accessible if required. The women had an understanding of safety that went well beyond "medical" safety. They believed that feeling, and being, emotionally and physically protected and avoiding unnecessary interventions were important components of safety. They also believed that their relationship with their midwife increased safety. There is an increasing body of research that

suggests that these factors do indeed increase safety.³³

Although these women had the opportunity to choose to have a planned home birth, they had to protect themselves from judgment by family, friends, and obstetricians who, if given the chance, would pressure them to do things differently. These findings are consistent with the findings in Cheney's qualitative study, "Homebirth as Systems-Challenging Praxis: Knowledge, Power, and Intimacy in the Birthplace."³⁴ The women in this study were able to protect themselves from pressure by avoiding anyone they thought would oppose their decision, by not telling family and friends unless they believed they would be supportive, and by developing support networks of women and families who had a home birth themselves. The need to do this raises ethical concerns. Why the intense pressure to give birth in a hospital with an obstetrician in the face of evidence that the alternative, planned home birth, is safe for healthy women? This deserves further study.

A U.S. survey of women's childbearing experiences, *Listening to Mothers II*, found that one-third of women who planned a hospital birth wanted a natural birth, yet less than 2 percent of the women had a birth characterized by the evidence-based care practices that facilitate normal physiologic birth, including allowing labor to start on its own, freedom of movement, labor support, keeping mother and baby together, giving birth in a non-supine position, and avoiding routine interventions.³⁵ The *Listening to Mothers II* findings suggest that the women in this study were correct in believing that giving birth at home would increase their chances of having a natural birth by avoiding hospital interventions like induction and restrictions on movement. The women also knew that at home they would be cared for only by people who cared about them and with whom they felt safe and protected. They knew that their baby would stay with them.

The women in this study questioned how safe U.S. hospitals are. In making the decision to have a planned home birth, the women opted out of a maternity care system that is neither evidence based nor respectful. Their decision to have a planned home birth challenges a maternity care system that needs to be challenged. Torres and de Vries describe the bioethics of current maternity care and highlight the ethical issues of non-evidence-based interventions and assembly line care.³⁶ "The bioethics of birth is about more than helping mothers accommodate to the existing system of maternity care; it is about challenging that system to promote better birthing."³⁷

These women's decision to have a planned home birth challenges the maternity system to promote birthing that is evidence based, and simultaneously is emotionally, physically, and socially safe for women and their baby. It also challenges obstetricians, hospitals, and insurance providers to value and protect women's choice of planned home birth and to integrate home birth into the U.S. maternity care system.

NOTES

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