Policy Statement on Planned Home Birth: Upholding the Best Interests of Children and Families

We strongly disagree with Chervenak et al. that the American Academy of Pediatrics (AAP) policy statement on “Planned Home Birth” diverges from its own primary principle, to promote the best interests of the child. First, the statement does not promote home birth. We begin, as the authors note, by agreeing with the statement of the Committee on Obstetric Practice of the American College of Obstetricians and Gynecologists that “hospitals and birthing centers are the safest setting for birth.” In addition, we state that the pediatrician should counsel expectant parents regarding the apparent risks of home birth in the United States. Subsequently, after the infant is born, we specifically promote the best interests of the child who is born at home by setting standards for care that adhere to those delineated in AAP publications.

The arguments made by Chervenak et al regarding the “best interests of the child” have several notable flaws. First, before delivery, the fetus is not an independent being (child), but a fetus, and the authors inexplicably ignore both the ethical principle of autonomy for the expectant mother and the difficult balance of maternal and fetal benefits and harms. Previous commentary by these authors advocates overriding both maternal and fetal rights, arguing instead for the “professional responsibility model of obstetric ethics, which emphasizes the importance of medical science and compassionate clinical care of both the pregnant and fetal patient. The result is that responsible medical care overrides the extremes of clashing rights.” In other words, it appears that physician beneficence is the dominant ethical principle, and that when a pregnant woman becomes an obstetric patient she gives up her autonomy and her decision-making capability to the physician. This interpretation of ethical principles results in a loss of control by the pregnant woman, a factor consistently reported as a reason women choose home birth.

Second, the authors appear to regard “safe” versus “not safe” as a dichotomous outcome (eg, “when in fact homebirth can never become [safe] under any circumstances”). However, this is not the case. Hospital birth is not uniformly “safe,” and home birth is not uniformly “unsafe.” Instead, there are gradations of multiple outcomes, and variable benefits and/or harms to both mother and child. For example, 1 way to express the difference in neonatal mortality is that in-hospital birth appears to improve neonatal survival over home birth from ~99.85% to 99.95%. This difference does not meet the high threshold generally set for overriding parental decisions for their children suggested by the AAP Committee on Bioethics and others. Moreover, hospital-based delivery is consistently associated with increased medical interventions (eg, Cesarean delivery rate >30%) that have long-term health consequences for women. In the United States, hospital-based delivery also has a high cost, which may result in financial hardship to families and economic harm to society.
And third, there are valid differences of opinion about what constitutes the best interests of the child. As stated by the AAP Committee on Bioethics in a reference cited by the authors, “the Academy acknowledges that this standard of decision-making does not always prove easy to define. In a pluralistic society, one can find many religious, social, cultural, and philosophic positions on what constitutes acceptable child rearing and child welfare. The law generally provides parents with wide discretionary authority in raising their children.”

The authors base their position in part on their analysis of birth certificate data from 2007 to 2010, which they claim shows outcomes “worse than those referenced in the AAP statement,” in particular a relative risk of 10.55 for a 5-minute Apgar score of 0 for hospital births is lower than neonatal mortality previously reported after hospital birth, calling into question the comparability of Apgar scores in different settings. Second, reviewing US birth certificate data from 2007 to 2010 (Table 1), one can see that the incidence of a 5-minute Apgar score of 0 was indeed much higher for home delivery; however, the rate of 5-minute Apgar scores <4 (a more robust measure because of the larger numbers in the cells) was much closer, and similar to previously reported figures. Given the well-known inadequacy of using the Apgar score to predict outcomes and the limitations of birth certificate data, caution needs to be used in interpreting these findings. Factors contributing to the apparent increase in adverse neonatal outcomes from home birth are likely to be multiple, as outlined in our statement.

One plausible contributor is the antagonistic attitude of many health care providers toward women who plan a home birth and the practitioners who attend them, as voiced by Chervenak et al. This and many other systemic impediments could potentially be ameliorated, as suggested by a small study from Canada where home birth practitioners are part of the overall health care delivery system, that found no increase in adverse neonatal outcomes after planned home birth. We do agree with the authors that the traditional hospital-based health care delivery system is less than optimal for women giving birth and efforts should continue to be made to improve it. We also agree that within the existing US health care paradigm, home is not the ideal setting for birth, even when planned. However, we firmly believe that the policy statement on planned home birth follows the AAP mandate to promote the best interests of children and their families, by acknowledging maternal and family autonomy and the complexity of their decision-making, by setting rigorous standards for care of infants born in any setting, and by promoting increased professional collaboration and communication.

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REFERENCES


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