Making Out-of-Hospital Birth Safer Requires Systems Change
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Birth is as safe as life gets. - Harriette Hartigan, direct-entry midwife

What one deems "safe" is inherently subjective, involving a series of judgments and a relative weighing of multiple (and sometimes conflicting) factors. Safety definitions are also culturally shaped; hospitals may be perceived as the safest place to deliver if childbirth is regarded as potentially pathologic and capacity to quickly address emergent complications is most highly valued. Recent evidence indicating that the risk for perinatal mortality is increased among women intending out-of-hospital birth supports this perspective. Alternatively, the home or birth center may be perceived as safest if childbirth is regarded as a normal physiologic event potentially harmed by routine obstetric intervention. Recent evidence also found that women intending out-of-hospital birth as compared with those delivering in-hospital were at significantly lower risk (5.3% vs 24.7%, \( P < .001 \)) for cesarean delivery, a surgery associated with higher rates of maternal mortality. In the United States, these perspectives are often at odds, while other societies have devised systems maximizing advantages of each setting.

The choice of birth setting is nothing if not contentious in the United States, and mothers-to-be commonly face scrutiny for their decisions. Despite these pressures, out-of-hospital births have steadily increased over the past decade, up 72% from 0.87% of US births in 2004 to 1.5% in 2014. This trend shows no sign of reversing; disengaging with the debate over whether out-of-hospital birth is safe and instead engaging examination of the factors that may make out-of-hospital birth safer is of critical import. Formally including home and birth center care in US maternity care systems will improve outcomes for the growing numbers of women seeking care outside of the hospital. In parallel, increasing the availability of physiologic birth in-hospital may decrease the number of women choosing out-of-hospital birth as a means of avoiding unnecessary intervention, with the added benefit of reducing iatrogenic maternal morbidity for the predominance of low- to moderate-risk women who choose hospital birth. While the vast majority of healthy women in the United States will deliver safely regardless of birth setting, these advances would temper polarization around birth setting, improve interprofessional collaboration, and increase the safety of our entire maternity care system.

Licensing and Guidelines

Several studies identify maternity care systems with higher rates of out-of-hospital birth and comparable or improved maternal outcomes with no (or minimal) increases in neonatal morbidity or mortality relative to the United States. These nations serve as models for increasing out-of-hospital birth safety. Notable examples include Canada, the United Kingdom, and The Netherlands.

Common features of these systems include high-quality training of midwives, integration of midwives in the maternity care workforce, and clear guidelines for patient selection. In the United Kingdom, Canada, and The Netherlands, midwives specialize in the care of low-risk pregnant and birthing women and are considered the most appropriate providers for women with uncomplicated pregnancies. Healthy women "risk out" of midwifery care and into physician care if they develop specific medical complications. Normalization and integration of midwifery care decreases political and cultural barriers separating in- and out-of-hospital providers, and allows for ease of collaboration with medical backup when complications arise.

Another important safety feature is the utilization of clear guidelines regarding candidates for out-of-hospital delivery. Such guidelines help facilitate a better fit between clinical resources and maternal risk level, for example, by

decreasing both the number of moderate- to higher-risk women giving birth outside the hospital and the number of low- and very low-risk women delivering in the hospital.

In addition to systems integration and clearer national criteria for patient selection, the United Kingdom and The Netherlands also adhere to uniform European Union education and licensure regulations for midwives. Uniformity and high standards of midwifery education may be another key to ensuring that women at increased risk are identified early and triaged into a more intervention-rich setting, and also that out-of-hospital midwives are skilled at recognizing and responding appropriately to unexpected complications. Uniform education and licensure may also increase safety by eliminating confusion around credentialing. Pregnant women in the United States are faced with the challenge of determining which of the many licensed and unlicensed midwives (eg, CNM, CM, CPM, DEM, LM, lay midwife) possess a skill set appropriate for attending her birth. Those in midwifery leadership positions in the United States are currently working together to align all domestic midwifery education and licensure criteria with International Confederation of Midwives standards. We believe that this has the potential to make out-of-hospital birth safer.

Issues With Hospital Transfers

Current estimates suggest that somewhere between 8% and 16.5% of US women intending to deliver outside of the hospital will transfer to the hospital during labor or in the immediate postpartum period. Intrapartum transfers of care have emerged as a key site of risk and also interprofessional contention. Improving coordination during this sensitive time is essential to improving safety. Specifically, timely transfer characterized by well-coordinated, interprofessional collaboration may increase safety through systems optimization. Care in Canada, the United Kingdom, and The Netherlands includes standardized transfer criteria and protocols that are familiar to both the transferring and the receiving provider. Factors that increase respectful and effective interprofessional communication may further decrease perceived barriers to transfer among out-of-hospital providers and may improve sharing of health records essential for maximizing safety. Greater uniformity and a commitment to disclosure of all relevant maternity care information during a transfer of care, again mirroring maternity care systems already functioning well, may be an important element in improving safety for families planning to deliver outside the hospital.

Working Together

Emotionally charged, moralistic arguments have dominated public discussion of birth setting, creating what has been called the home/hospital divide. Yet, a satisfying birth process, a healthy woman, and a healthy child are mutual goals. How can we work together to address our shared responsibility for increasing access to safe, affordable, and empowering birthing care? And how can we expand safe maternity care options for all US women? Shifting discourses away from how women should personally define safety and toward systems-level changes that increase safety for all women across all birth settings will help to focus our efforts in positive and productive directions.

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References


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