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Ethics and professional responsibility: Essential dimensions of planned home birth

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ABSTRACT

Planned home birth is a paradigmatic case study of the importance of ethics and professionalism in contemporary perinatology. In this article we provide a summary of recent analyses of the Centers for Disease Control database on attendants and birth outcomes in the United States. This summary documents the increased risks of neonatal mortality and morbidity of planned home birth as well as bias in Apgar scoring. We then describe the professional responsibility model of obstetric ethics, which is based on the professional medical ethics of two major figures in the history of medical ethics, Drs. John Gregory of Scotland and Thomas Percival of England. This model emphasizes the identification and careful balancing of the perinatologist's ethical obligations to pregnant, fetal, and neonatal patients. This model stands in sharp contrast to one-dimensional maternal-rights-based reductionist model of obstetric ethics, which is based solely on the pregnant woman's rights. We then identify the implications of the professional responsibility model for the perinatologist's role in directive counseling of women who express an interest in or ask about planned home birth. Perinatologists should explain the evidence of the increased, preventable perinatal risks of planned home birth, recommend against it, and recommend planned hospital birth. Perinatologists have the professional responsibility to create and sustain a strong culture of safety committed to a home-birth-like experience in the hospital. By routinely fulfilling these professional responsibilities perinatologists can help to prevent the documented, increased risks planned home birth.

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Introduction

Planned home birth is an excellent case study documenting the importance of ethics and professionalism in modern obstetrics. Based on our previous work,[1,2] in this article we develop this case study in three steps: (a) summarizing recent evidence about the experience with planned home birth in the United States[3–6]; (b) presenting the professional responsibility model of obstetric ethics[7,8]; and (c) identifying the implications of the evidence and this model for the professional response of perinatologists to planned home birth.

Summary of evidence of experience with planned home birth in the United States

The authors formed an international study group on planned home birth, under the auspices of the World Association of Perinatal Medicine and the International Academy of Perinatal Medicine. In March 2013, two of us (F.A.C. and A.M.G.) attended a workshop sponsored by the Institute of Medicine and National Research Council, An Update on Research Issues in the Assessment of Birth Settings.[9] Among those represented was the American College of Obstetrics and Gynecology (ACOG), the Society for Maternal–Fetal Medicine, the American Academy of Pediatrics (AAP), and the Centers for Disease Control and Prevention (CDC). One of the authors (F.A.C.) presented the results of our group's initial analysis of CDC data[4] about the increased risk of planned home birth and on the basis of this evidence was the only speaker to strongly warn against the dangers of planned home birth.[9pp. 134–136] It was clear to all of the members of our international study group that further analysis of CDC birth certificate data was required to establish a reliable scientific account of the outcomes of planned home birth in the United States, using the best database for such analysis.

The outcomes of planned home birth attended by midwives and the outcomes of hospital birth attended by midwives and physicians in term, singleton pregnancies ≥2500 g birth weight have now been analyzed. The comparator groups were midwives either attending planned home birth or hospital deliveries. We have completed analyses of neonatal outcomes,[3,4] reliability of Apgar scoring,[5] and risk assessment.[6] We underscore that all of our analyses to date show that midwife-attended hospital births have similar or better outcomes when compared to physician-attended hospital birth. We explored the hypothesis that planned midwife-attended planned home birth was riskier than midwife-attended and physician-attended hospital birth, by adhering strictly to accepted standards of statistical analysis.

With respect to neonatal outcomes, our analyses have shown that planned home birth by midwives in the United States had significantly increased relative risks (RR) for a 5-min Apgar score of zero (RR = 10.55) and neonatal seizures or serious neurological dysfunction (RR = 1.88).[3] We have also shown that planned home birth by midwives had significantly higher relative risks of total mortality (RR = 3.87), gestational age ≥41 weeks (RR = 6.76), and women with first birth (RR = 6.74). In this article we also showed that excess total neonatal mortality was 9.32 per 10,000 births and the excess early neonatal mortality was 7.89 per 10,000 births.[4]

Our analyses have shown that a 5-min Apgar score of 10 was assigned by midwives at planned home births in 52.44% of all deliveries, as compared to hospital midwives of 3.71% and physicians (3.67%) with an odds ratio (OR) of 28.95. We concluded that there is an inexplicable bias of high Apgar scores assigned by midwives at planned home delivery.[5]

Our analyses have also shown that midwife-attended planned home births are not low risk, as some have claimed, but have significantly increased risk factors that are not within the clinical criteria set by ACOG and AAP for planned home birth: breech presentation 1 in 135 births (OR = 3.19); prior cesarean delivery 1 in 22 births (OR = 2.08); twins 1 in 156 births (OR = 2.06); and gestational age ≥41 weeks 1 in 3.54 births (OR = 1.71). In addition, we found that two out of three midwives, attending planned home births, did not meet ACOG and AAP recommendations for certification by the American Midwifery Certification Board.[6]

Our analyses of the largest, most reliable database on birth in the United States clearly documents that midwife-attended planned home birth has significant and marked increased of 5-min Apgar score of 0, neonatal seizures or serious neurological dysfunction, and early and total neonatal mortality, that midwife-assigned Apgar scores at planned home birth are apocryphal, and that risk assessment by midwives attending planned home birth is suboptimal. This documented clinical reality of preventable, increased significant adverse neonatal outcomes, biased Apgar scoring, and poor risk assessment should not be ignored by the professional obstetric community.

The professional responsibility model of obstetric ethics

The response of obstetricians, hospital managers and healthcare politicians should be guided by the professional responsibility model of obstetric ethics, which is based on the ethical concept of medicine as a profession.[7,8] It is commonly believed that medical professionalism originates in the Hippocratic Oath and other ethical texts in the Hippocratic Corpus.[10] The problem with this belief is that the Hippocratic Oath can reasonably be read as a guild oath, the primary purpose of which was to secure the fealty of young men who were not the sons of physicians. "It is clear that the essential role of the *Oath* was to preserve the interests and privileges of the family possessing medical knowledge from the moment it was made available to others."[11p. 47] The first section of the Oath stipulates the obligations of these young men to the masters of the guild, solemnized in a "written contract,"[12] i.e., a loyalty oath.

Obstetric practice figures prominently in the prescriptions and proscriptions that follow are explained but can be read as self-interested, e.g., avoiding high mortality rates and the ruined reputation that they bring in their wake to physicians whose patients die in high numbers. In ancient Greek medicine, a pessary was a stone placed in the cervix of a pregnant woman to cause it to dilate, resulting in uterine contractions that caused an induced abortion. In an era