Editorials

Promoting Safety in Community-Based Birth Settings

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Births outside of the hospital setting are uncommon in the United States; however, since 2004, home birth rates have increased by 77%, and rates at community birth centers have doubled.[1] Although controversy regarding the safety of giving birth outside of the hospital setting continues, professional organizations agree that a pregnant person has the inherent right to choose where they wish to give birth.[2-4] Although studies of home birth outcomes in the United States have demonstrated increased perinatal mortality,[5,6] data from other high-resource countries have been more reassuring.[7-9] These differences in perinatal outcomes may be due to a variety of factors, including inconsistent training standards for U.S. midwives, higher-risk patients giving birth in U.S. community-based settings,[10] and poor integration between U.S. community- and hospital-based maternity care services. Family physicians can improve perinatal outcomes for births at home and in community birth centers by facilitating access to physician consultation before, during, and after the birthing process.

Several prominent news outlets have reported increased interest in home births during the COVID-19 pandemic because many pregnant patients are afraid of contracting COVID-19 in the hospital.[11,12] In response to these concerns, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians (AAFP), the American College of Nurse-Midwives, and the Society for Maternal-Fetal Medicine released a joint statement asserting that hospitals and community birth centers, with the appropriate accreditation, are the safest places to give birth in the United States.[13]

Home births are associated with lower rates of obstetric interventions, including cesarean delivery, oxytocin augmentation, and episiotomy, and with lower rates of obstetric complications such as anal sphincter lacerations and maternal infections.[14] Psychological trauma from previous birth experiences and/or a history of other traumatic life experiences may cause a pregnant person to fear maltreatment or loss of autonomy if they give birth in a hospital. Mistreatment in labor occurs more often in the hospital setting compared with home births (28.1% vs. 5.1%).[15] Systemic racism and the stress it creates account for some of this difference.[16,17] Birth centers supported by public funding such as Medicaid, which pays for more than 40% of all births, and a higher proportion of births for persons of color[18] may achieve improved satisfaction with the birthing experience, lower rates of preterm births and cesarean deliveries, and lower costs for delivery.[19]

The safety of home or birth center birth can be improved by adequate birth attendant training, access to emergency obstetric care, and careful risk assessment throughout the prenatal and intrapartum periods. Certified professional midwives should be trained to international standards and licensed in every state as described in the article by Lang and colleagues in this issue of *American Family Physician*.[20,21] Physician consultation can improve prenatal care, assist with risk assessment, and facilitate timely transfer to hospital care if indicated. Patients' experiences during prenatal care or hospital transfer may be adversely affected in some communities by the unwillingness of community- and hospital-based physicians and midwives to collaborate.[22]

The AAFP, in collaboration with other professional organizations representing obstetrics and gynecology, midwifery, pediatrics, and patients, participated in the national Home Birth Summits in 2011-2014, which led to the development of model transfer guidelines.[23] These guidelines define the roles of community- and hospital-based midwives and physicians to improve perinatal outcomes and maternal birth experience. Physicians, midwives, and nurses should use terminology free of negative connotations. Describing a pregnant person as a "failed home birth," for example, is depersonalizing and may be viewed as judgmental. Labeling certified midwives or certified professional midwives who are not nurses as "lay midwives" is inaccurate and inappropriate. Substituting the term "community birth" for "out-of-hospital birth" removes the assumption that hospital birthing is normative and is preferred.[24]

Pregnant patients with a fetus in breech presentation near term, a multiple gestation, or a previous cesarean delivery should be counseled that home birth is not recommended because of the increased risk of adverse neonatal outcomes.[2,10,25] Many patients in rural areas lack access to trial of labor after cesarean (TOLAC), despite AAFP and ACOG efforts to support maternal choice.[26,27] Persons deemed ineligible for maternity care in their local hospital because of a history of cesarean delivery may choose the increased risk of a local home birth rather than transfer care outside of their community.[26-28] Supporting the options of TOLAC in rural hospitals and planned vaginal breech delivery for those who meet criteria may decrease the likelihood of pregnant persons with these risk factors choosing home birth.

The proportion of pregnant persons who live in "maternity care deserts" is increasing as rural maternity care units, or entire hospitals, close.[29] For some rural residents, a hospital birth may be preferred by the patient and/or their clinicians, but geographic isolation may limit access. The establishment of rural birth centers may improve maternal satisfaction and access to safe care for low-risk pregnancies, and decrease obstetric interventions. Education such as AAFP's Advanced Life Support in Obstetrics course[30] is particularly important for midwives practicing in community birth settings, because they may encounter complications such as shoulder dystocia and postpartum hemorrhage remote from physician assistance.

Although few physicians in the United States attend community births, family physicians play an important role in improving the safety of community birthing by offering counseling on the choice of birth setting, consultation, and collaboration during prenatal care, and by facilitating the process of maternal or newborn transfer when necessary. We encourage family physicians to pursue professional training and education on community birth to support the shared goal of an empowered and safer birth for every pregnant person.

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