IS HOMEBIRTH FOR YOU?

6 Myths About Childbirth Exposed

- According to a CDC report in 2003, in 24 other countries, more babies survive their first months of life than in the U.S. Considering that the US has the most expensive and highly sensitive technology—this is astounding. However, even more astounding is the top 5 countries with the lowest rates have almost 95 percent of their mothers using trained midwives to deliver their babies.
- In those top 5 countries—most insurance carriers will not cover obstetrician run births unless the woman has been proven to be very high risk. Midwives are the choice by insurance companies in countries where death among newborns is rarest!
- Respiratory distress among newborns was 17 times higher in the hospital than in the home.
- The U.S. has the highest obstetrical intervention rates as well as a serious problem with malpractice suits. Most midwives do not carry malpractice and thus must carefully screen their clientele to be sure they are aware of the risks they take and the normalcy and safety of natural childbirth.
- Each intervention in a normal labor has it own set of risks and actually leads up to a mother being encouraged to have a cesarean section.
- Strict and expensive infection control procedures have still not eliminated hospital-caused infections.
- In 2004, the average National fee charged by an obstetrician/hospital for a normal, non-intervention pregnancy, labor and delivery was $8,500 to $10,500.
- In 2004, the average National fee charged by a trained and knowledgable home birth midwife for complete prenatal care, labor, delivery, and postpartum care was between $2500 and $3500.

Myth #1 — Hospital births are statistically safer than homebirths.

Safety in childbirth is measured by how many mothers and babies die and how many survive childbirth in less than perfect health.

Studies done comparing hospital and out-of-hospital births indicate fewer deaths, injuries and infections for homebirths supervised by a trained attendant than for hospital births. No such studies indicate that hospitals have better outcomes than homebirths.

While maternal death rates have vastly improved since the turn of the century, factors like proper nutrition and cleanliness have played a big part in the change.

Overall neonatal death rates have also improved since the 30s, but homebirths appeared to be safer even then. In 1939, Baylor Hospital Charity Service in Dallas, Texas, published a study that revealed a perinatal mortality rate of 26.6 per 1,000 live births in homes compared to a hospital birth mortality rate of 50.4 per 1,000.[1]

Since the 1970s, research done in northern California, Arizona, England and Tennessee all point to the relative safety of homebirth.[2] The only matched population study, comparing 1,046 homebirths with 1,046 hospital births, was published in 1977 by Dr. Lewis Mehl, a family physician and medical statistician.[3]

While neonatal and perinatal death rates were statistically the same in Mehl's report, morbidity was higher in the hospital group: 3.7 times as many babies born in the hospital required resuscitation. Infection rates of newborns were four times higher in the hospital, and the incidence of respiratory distress among newborns was 17 times higher in the hospital than in the home.

A six-year study done by the Texas Department of Health for the years 1983-1989 revealed that the infant mortality rate for non-nurse midwives attending homebirths was 1.9 per 1,000 compared with the doctors' rate of 5.7 per 1,000.[4] Certified nurse midwives' mortality rate was 1 per 1,000 and "other" attendants accounted for 10.2 deaths per 1,000 live births.[5]

A study of 3,257 out-of-hospital births attended by Arizona licensed midwives between 1978-85 shows a perinatal mortality rate of 2.2 per 1,000 and a neonatal mortality rate of 1.1 per 1,000 live births.

In testimony before the U.S. Commission to Prevent Infant Mortality, Marsden Wagner MD, European Director of the World Health Organization, suggested the need in the U.S. for a "strong independent midwifery profession as a counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process."[6]

Wagner states that in Europe midwives far outnumber physicians: "In no European country do obstetricians provide the primary health care for most women with normal pregnancy and birth." He states that the U.S. has the highest obstetrical intervention rates as well as a serious problem with malpractice suits and concludes that a strong, independent midwifery service in the U.S. would be a most important counterbalance to the present situation.

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1. *The Five Standards of Safe Childbearing*, 1981, Stewart, p. 241.
2. Ibid, p. 115-116, 127, 243-246.
3. Ibid, p. 247-253.
4. *Texas Lay Midwifery Program, Six Year Report, 1983-1989*, Bernstein & Bryant, Appendix VIIIf, Texas Department of Health, 1100 West 49th St., Austin, TX 78756-3199.
5. *Labor Pains: Modern Midwives and Homebirth*, Sullivan & Weitz, 1988.
6. *Mothering*, Jan/Feb, 1990

Myth #2 — You can get more professional attention in a hospital than you could get at home.

In the hospital, obstetricians do not routinely sit at the bedsides of their laboring patients but rely on machinery and others for information — then appear at the last minute in the delivery room. Most physicians do not build a relationship of supportive rapport with each patient or offer much encouragement to give birth naturally.

Labor and delivery room nurses by and large enjoy giving support to women during childbirth. Hospital life, however, involves a great deal of paperwork, personnel changes by the clock and wild fluctuations in how many women each nurse must be responsible for. And nurses have no authority to stop an impatient doctor from trying to "speed up" a slow-but-steady, normal labor.

Over the last few decades, women have protested against the cold and clinical atmosphere of birthing wards, and many hospitals have bent under popular pressure to make their sterile environments more home-like.[1] Most allow women's partners into labor and delivery rooms, and some even accept the presence of a professional labor coach.

But for many women, the natural act of giving birth does not belong in a clinical environment when all is well. Planned homebirths with a trained attendant present have good outcomes.

While statistics indicate that unplanned or unattended homebirths have worse outcomes than hospital births, planned homebirths with a trained attendant present have good outcomes.[2]

There are a variety of trained and experienced homebirth practitioners from which to choose — physicians, certified nurse midwives and direct-entry, or non-nurse midwives. A small number of doctors, some of whom are members of the American College of Home Obstetrics, maintain homebirth and/or clinic practices. Several birth centers in the U.S. are physician-owned and operated.

Certified nurse midwives are registered nurses who have continued their education in the specialty of obstetrics. Most CNMs work only with physician backup in a hospital environment, but a few have homebirth practices.

Midwifery is basically a system of wellness care given by professional midwives to women and infants during the childbearing year, and in many other countries midwives are the primary care givers in maternity systems with better neonatal mortality rates than ours. Midwives are trained to watch for deviations from health throughout the pregnancy and labor and refer their clients to a physician if necessary.

The number of direct-entry midwives has increased in the last twenty years due to more demand for their services. Most non-nurse midwives have completed a course of study and then furthered their education by apprenticing with a more experienced midwife. These midwives practice legally in only 12 states, some of which require them to be licensed. Where midwifery is illegal, the states have declared these time-honored professionals to be "practicing medicine without a license."

Midwives practice freely in all but 20 states. They do so either under statutory regulation or in states with no specific midwifery laws. [Ed. — Information about the current midwifery legal situation in individual states or Citizens for Midwifery Grassroots Network.]

Prenatal visits to an obstetrician's office or public health department usually involve long waiting periods before seeing a doctor or nurse for a very brief checkup. By contrast, each prenatal visit with a midwife is usually relaxed, friendly and can last from 30 minutes to an hour. Midwives traditionally use this time for teaching the benefits of good nutrition, exercise, hazards to avoid and how to prepare for a natural birth.

Though the educational background of midwives varies widely, many collect laboratory specimens, monitor the baby's heart rate for signs of fetal distress during labor, carry oxygen equipment and are trained in cardiopulmonary resuscitation.

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1. *A Good Birth, A Safe Birth*, 1990, Korte & Scaer, p. 8-21.
2. Ibid, p. 64-68.

Myth #3 — The more modern technology you have on hand, the easier the birth will be.

In a sincere effort to catch complications early and produce healthier babies, medical science has changed the atmosphere surrounding birth from one of a circle of loving support around laboring women to one of space age technology in a laboratory setting.

Though technology can save lives in a crisis, the routine use of technology can interfere with the normal birth process.

It is common in hospitals to use intravenous fluids and electronic fetal monitors to ensure that the mother stays well hydrated and that each contraction and beat of the baby's heart is recorded. However, many women dislike being confined to a bed with needles in their arms and belts around their abdomens.

Women who are allowed to move about freely during labor complain less of back pain, and many childbirth authorities feel the motion of walking and changing positions can enhance the effectiveness of the contractions.

Some hospitals still require women to birth lying flat on their backs with their legs held high in stirrups. Because the position defies gravity and makes pushing less effective metal forceps are sometimes used to pull the baby out of the vagina. Research shows that forceps are rarely used when women are allowed to assume a position of comfort during the bearing down stage.

Obstetricians frequently rupture the bag of waters surrounding the baby in order to speed up the birthing process. This procedure automatically places a time limit on the labor, as the likelihood of a uterine infection increases with each passing hour in the hospital after the water is broken.

Once the protective cushion of water surrounding the baby's head is eliminated, the belt monitoring the baby's heartbeat may be exchanged for a scalp electrode — a tiny probe that is screwed into the baby's scalp to continue monitoring the heart rate and to collect information about the baby's blood.

Each of these interventions in a normal labor has its own set of risks, and none of the above procedures has ever been proven to be more advantageous in eliminating complications or to produce healthier babies.

A recent study published in a medical journal states that the routine use of electronic fetal monitors, compared to the old-fashioned method of listening to the baby's heartbeat after contractions with a fetoscope, may actually cause more problems than it prevents.[1] In eight randomized clinical trials, perinatal mortality was not reduced with electronic fetal monitoring. And perhaps because electronic monitoring can lead to unnecessary cesareans, birth outcomes were mostly superior in the groups monitored by fetoscope.[2]

Today at least 25 percent of all birthing mothers are delivered surgically. This compares to an average c-section rate of about 10 percent in other countries with better mortality rates.[3] These numbers indicate that we are not getting better outcomes with more c-sections.

Several decades ago, in an effort to lessen the pain of childbirth, physicians routinely gave laboring women pain-killing and anesthetic drugs. Over the years the use of most of these medications has subsided somewhat after studies revealed that drugs given to the mother had adverse effects on the baby, including asphyxia, hypoxia and even brain and central nervous system damage.[4]

Drugs are still available to laboring women in the hospital, though no drug given in childbirth has been proven to be safe for the baby.[5]

Women who have taken drugs in labor report decreased maternal feelings towards their babies and an increase in the duration and severity of postpartum depression.[6]

The artificial hormone pitocin, a drug given to intensify labor and to contract the uterus after childbirth also has potential side effects, including rare cases of uterine rupture and a slight increase in jaundice in the newborn.[7]

Interrupting the natural process of birth with technological wizardry can cause more harm than good.

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1. *New England Journal of Medicine*, March 1, 1990.
2. *The Cutting Edge*, Feb. 1990, p. 4, P.O. Box 1568, Clayton, GA 30525.
3. *Birth Without Surgery*, Carl Jones, 1987, p. xii.
4. *The Five Standards of Safe Childbirth*, 1981, Stewart, p. 185.
5. Ibid, p. 175
6. *A Good Birth, A Safe Birth*, 1990, Korte & Scaer, p. 18, 201-209.
7. *The Five Standards of Safe Childbirth*, 1981, Stewart, p. 300.

Myth #4 — A hospital is a more sanitary place to have a baby than at home.

Childbed fever killed thousands of women in the 19th century — about the time physicians, who also cared for the ill and dying, began to attend births in clinics. As hospitals became the places to go for birth and death, infections became a plague upon childbearing women and other hospital patients.

About 100 years ago, in Austria, a doctor named Ignaz Semmelweis attempted to lower the number of maternal deaths from infections — as high as 40 percent of those delivering at the Vienna maternity hospital.[1] Semmelweis discovered that simply by washing their hands between performing autopsies and attending births, the rate of infections caused by doctors dropped dramatically. Semmelweis was ridiculed by his colleagues, and it wasn't until five years after his death that his findings began to gain acceptance. With the advent of aseptic technique in the late 1800s and the development of antibiotics in the 1940s, gradual improvement was seen. [Ed. — As antibiotic-resistant bacteria have evolved so that they are unaffected by antibiotics, it can be expected that this trend will be reversed, and we can expect to see an increase in deaths from hospital-acquired infections.]

In the 1930s, studies in New York City and Memphis, Tennessee, show that fewer women died from infections and hemorrhage during homebirths than died from the same complications in the hospital.[2]

Today, strict and expensive infection control procedures have still not eliminated nosocomial, or hospital-caused infections from common and dangerous organisms, like resistant strains of staphylococcus.

According to a report in the *Wall Street Journal*, the nation's hospital-regulating agency, The Joint Commission on Accreditation of Health Care Organizations, is failing to enforce infection control standards — compromising the health of hospital patients: "The Joint Commission allows dangers to health and safety to go uncorrected for weeks, months and even years. Sloppy, irresponsible hospitals have little to fear from the Commission: punishment in recent years has been nearly nonexistent."[3]

Each family becomes accustomed to its own household germs and develops a resistance to them. Since fewer strangers are likely to be present at a homebirth than at a hospital birth, the chances of acquiring foreign germs are less likely in a homebirth situation.

Every effort is made to provide a clean environment at homebirths. Midwives and homebirth doctors wear sterile gloves and use sterilized instruments for cutting the umbilical cord.

Homebirth research studies indicate much lower rates of infection in the mother and the baby than is likely in the hospital. In a 10-year study (1970-1980) of 1,200 births at the Farm in Summertown, Tennessee, 39 mothers suffered postpartum infections, and only one baby developed septicemia.[4]

Calling the hospital nursery a cradle of germs, Dr. Marsden Wagner, European Director of the World Health Organization, warned doctors at an international medical conference in Jerusalem in the spring of 1989 that hospital births endanger mothers and babies primarily because of impersonal procedures and overuse of technology and drugs.[5]

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1. *The Birth Gazette*, Fall, 1987, review of *The Cry and The Covenant*, p. 32-33.
2. *The Five Standards of Safe Childbearing*, 1981, Stewart, p. 240-241.
3. *The Wall Street Journal*, Oct. 12, 1988.
4. *The Five Standards of Safe Childbearing*, 1981, Stewart, p. 127.
5. *Mothering*, Oct/Nov/Dec, 1989.

Myth #5 — A hospital is the most comfortable place to have a baby.

The idea of being comfortable during childbirth may strike many mothers who have delivered in the hospital as impossible. They remember being confined to a hospital bed, denied food and water, separated from their other children and supportive family members and friends, enduring frequent internal examinations and vital sign checks, being transfered from one room to another on a stretcher at the peak of labor's intensity and having their legs strapped into stirrups.

Birthing rooms and their homey furnishings are an effort to eliminate some of the stress and discomfort that comes from being in the strange surroundings of the hospital.

Studies show that labor can be compromised by an unfamiliar environment. Discomfort and fear can actually increase the pain experienced in childbirth, while relaxation can diminish maternal stress, improve oxygen flow to the baby and facilitate labor.

In her own home a laboring woman has "the home court advantage." She can move about freely, wear what clothing she chooses, sip on energizing juices, continue caring for other children as she is able, relax in a warm tub of water, have her feet rubbed by loving friends and try different birthing positions. Normal labor is a healthy stress for the baby, clearing the lungs of fluid and preparing it to take its first breaths.

After the birth, the baby is never taken from its mother's side. The entire family can climb into a clean bed for a much needed cuddle and nap. The emotional bonding that takes place in the moments after birth between mother and child and between the baby and the entire family promotes well being, encourages breastfeeding and speeds recovery of the mother.

Myth #6 — It's impossible to find any qualified person to assist you in having a baby at home.

While discussion over the pros and cons of homebirths and who should attend them continues in medical circles and around supper tables, thousands of healthy babies are being born in their own homes each year.

Homebirth is not for every woman. It takes a high degree of commitment to health and learning and a high level of responsibility to go against the majority who believe hospital births are better.

As you consider where to give birth, read the books listed in the Resource Guide. Talk to women who have given birth at home, in birthing centers, in birthing rooms and in hospital delivery rooms. Discuss your concerns with your physician and your midwife.

Interview several alternative birth practitioners in your area. Assess the level of skill, integrity, knowledge and philosophy of each to discover if they are compatible with your expectations. Whereas obstetricians deliver the great majority of babies in hospitals, some are operating alternative birthing centers. Family practitioners who attend births can still be found, but their ranks are decreasing because of the soaring expense of malpractice insurance.

Certified nurse midwives are located in many metropolitan areas, and in some hospitals offer primary maternity care in a clinic and birthing room setting. Well-educated and trained direct-entry midwives are specialists in normal childbirth. Some operate birth centers, and many have homebirth practices all across the country.

In 2004 the average family in the U.S. paid about $8,500 for an uncomplicated hospital birth, according to a Health Insurance of American survey of 173 community hospitals, 70 childbirth centers and 153 licensed midwives.[1]

Breakdown of costs for a hospital birth include an average physician's fee of $4,500 ($6,500 for a cesarean), and hospital costs (not including other fees like the services of an anesthesiologist) of about $4,000. If you factor in anesthesia for epidurals and a delivery room for a cesarean section, the cost could rise by another $4,000 or more.

The average fee charged by a midwife was between $2,500 and $3,500, a price that includes prenatal care, childbirth classes and supplies, complete labor and delivery, and postpartum check ups (IN YOUR OWN HOME) while a physician's fee does not.

Which setting and type of birth attendant is right for you? In some states, your choices are limited based on laws that restrict the practice of midwives. Friends of Homebirth was founded in 1989 with the goal of working to ensure your right to choose homebirth with a trained attendant. Homebirth is a reasonable choice for many families, and restrictive legislation must give way to the Constitutional right of responsible parental choice.

To find alternative birth attendants in your area, contact childbirth educators and your local La Leche League group. You might also check with health food stores, well-woman health centers and your public health department.