In Search of a Common Agenda for Planned Home Birth in America

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ABSTRACT

Leading maternity provider organizations in North America have been in conflict about birth at home and birth centers, debating issues related to safety, access, the value of obstetric intervention, and patient autonomy. In today's environment, childbirth educators and doulas are often required to explain to parents why physiological birth and evidence-based, low-technology methods of labor and birth care are not available in every setting, and why maternity providers disagree about birth place. There are very few regions in the United States where home birth providers are integrated into interprofessional provider networks that allow for seamless care across birth settings. In October 2011, multidisciplinary leaders met at a Home Birth Consensus Summit in Warrenton, Virginia, to discuss the status of home birth within the greater context of maternity care in the United States. This article describes the intent and outcomes of the summit. Four of the nine consensus statements developed at the summit are of particular interest and importance to mothers and families and, hence, to childbirth educators and advocates. Consumers, educators, and birth advocates are encouraged to widen the circle, identify communications experts, lead individual projects, or serve as advisors.

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Throughout the expansion of technocratic birth over the last 60 years, leading maternity provider organizations in North America have been in conflict about birth at home and birth centers, debating issues related to safety, access, the value of obstetric intervention, and patient autonomy. Simultaneously, payors and policy makers have instituted significant regulatory, logistic, financial, and legislative barriers to the provision of home birth services in some jurisdictions. The malpractice environment and regional differences in malpractice legislation

also contribute significantly to variations in availability of birth setting options. In addition, differences in regional or geographic conditions for practice and/or differences in cultural expectations around site of birth restrict options. In today's environment, childbirth educators and doulas are often required to explain to parents why physiological birth and evidence-based, low-technology methods of labor and birth care are not available in every setting and why maternity providers disagree about birth place.

Although birth in the hospital became the most common site in the United States after the 1940s, a small but consistent number of women seek domiciliary birth each year. Recent publications suggest that, in the last 20 years, women in the United States have increased their interest in planned home birth (Declercq, Paine, & Winter, 1995; MacDorman, Menacker, & Declercq, 2010). Researchers have described the factors affecting women's choice of planned home birth and satisfaction with home birth as the perceived differences in women's ability to control the environment and process of care. Women describe an increased sense of safety at planned home births as facilitated by increased privacy, comfort, and convenience; greater cultural and spiritual congruency; an improved power balance with medical providers; and the ability to facilitate family involvement in a relaxed, peaceful atmosphere. They also appreciate the documented decrease in the rates of medical interventions. These conditions appear to contribute to women's self-determination and empowerment, which in turn allows them to fully participate in decision making around aspects of their care (Birthplace in England Collaborative Group, 2011; Christiaens & Bracke, 2009; Cunningham, 1993; Davies, Hey, Reid, & Young, 1996; Hildingsson, Waldenström, & Rådestad, 2003; Janssen, Carty, & Reime, 2006; Janssen, Henderson, & Vedam, 2009; Madi & Crow, 2003; Morison, Percival, Hauck, & McMurray, 1999; Soderstrom, Stewart, Kaitell, & Chamberlain, 1990).

Rights to choice and self-determination are core values in America and now are being raised in health-care discourse. However, a woman can only exercise choice of birth site if she has unrestricted access to maternity providers in all settings. A qualified provider can assist a woman to assess her birth site options according to her health status and distance to appropriate maternity care resources. Ideally, those providers offer care across all settings and are fully integrated into a network of maternity care services at all levels. In the United States, midwives are the only maternity care providers who currently offer choice of birth place.

Unfortunately, there are very few regions in the United States where home birth providers are integrated into interprofessional provider networks that allow for seamless care across birth settings. These restrictions may exist in part as a result of attitudes and beliefs that are particular to the professional culture

and/or deficiencies in health human resources essential to providing safe home birth. Research has demonstrated that provider attitudes toward, and knowledge of, maternity care options have a significant influence on patient choice. Providers are known to present options that are congruent with their own education, experience, and scope of practice (Cheyney, 2008; Davies et al., 1996; Floyd, 1995; Lindgren, Rådestad, Christensson, Wally-Bystrom, & Hildingsson, 2010; Reime et al., 2004; Shaw & Kitzinger, 2005; Vedam, Aaker, & Stoll, 2010; Vedam, Stoll, White, Aaker, & Schummers, 2009). As a result, differences in birth places that women choose may represent the nature of informed choice discussions women have with their caregivers, rather than their own inclination.

On October 20–22, 2011, 68 multidisciplinary stakeholders and leaders met at the Home Birth Consensus Summit in Warrenton, Virginia, to discuss the status of home birth within the greater context of maternity care in the United States. Delegates were drawn from nine identified stakeholder groups: home birth consumers; consumer representatives; home birth midwives; maternal–child health collaborating providers (including pediatrics, labor and delivery nursing, neonatal care providers); obstetricians and obstetric family practice physicians; leaders with expertise in health-care models, systems, and hospital administration; insurance (liability and payors); health policy, legislators, regulators, and ethicists; and public health, research, and education. Using the Future Search process for organized discovery of common ground, delegates explored every facet of the existing maternity care system, engaged in frank and productive conversations, and proposed ways to move forward. All stakeholder delegates were engaged in this consensus-building process. Previously, the divergence across stakeholders has driven an unwillingness to even discuss the subject across professions. Hence, the summit's multidisciplinary steering committee chose the Future Search methodology to first establish the areas of common ground before addressing those areas of disagreement. The committee's goal was to form multistakeholder and multiperspective working groups so that areas of disagreement could be addressed in a detailed and careful fashion. It was apparent that the conflicting agendas and feelings among professionals, and the lack of understanding of each other's world are so ingrained that they were impeding progress.

During the 24 months of preliminary planning for the Home Birth Consensus Summit, the multidisciplinary steering committee discussed possible

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outcomes several times. Funders wanted a listing of “deliverables,” but some committee members wanted assurances that their participation would not imply endorsement of specific deliverables. As chair of the steering committee, it became my role to repeatedly explain that the success of the Future Search method begins with the discovery of a shared agenda through a consensus and collaborative process. This meant that outcomes and next steps could not be predicted before the summit participants engaged and either reached agreements or could not find consensus in any subtopic.

Remarkably, throughout the 72 hours of face-to-face exercises during the summit, the dialogue was held in good faith, was respectful and complex, and revealed multiple issues that were of common concern as well as sources of misunderstanding. Some delegates came to the summit with no opinion at all; others came with opposition and became more open to discussion about the conditions under which we should support good care across settings. Other delegates who were “pro home birth” became more open to the complexity of the issues and more aware of the value and seriousness of the cautionary concerns that were eloquently expressed by the obstetric, midwifery, pediatric, public health, research, safety and quality, hospital administration, consumer, Centers for Disease Control and Prevention, legislative, legal, payor, managed care, and liability experts present. The process specifically allowed all opinions to be expressed, multiple times. The process also catalyzed unusual and unprecedented alliances between practitioners and consumers, researchers and ethicists, and physicians and midwives.

By the close of the Home Birth Consensus Summit, the attending stakeholders and leaders developed nine consensus statements that represent areas of common ground and shared priorities for further discussion and action. Several newly formed multidisciplinary workgroups agreed to carry initiatives forward. Simultaneously, many individuals identified personal commitments within their own spheres of influence related to improving conditions for women planning home birth. Other leaders reported on their plans to review the consensus statements with their national organizations and constituents for endorsement, commentary, and/or action.

The most important factor that contributed to the success of the summit was that individuals who agreed to attend were interested enough to enter into a dialogue. Others who may have been more extremely committed to held views declined to attend. Some from both sides indicated interest but were not free at the

time but, universally, asked to be engaged in ongoing efforts. Since the summit, critics have suggested that all of the delegates were favorable to home birth (i.e., that the deck was stacked) and that the overarching consensus statements were simply “motherhood and apple pie.” However, a quick scan of the delegates’ profiles will quickly dispel the notion of a lack of diversity of opinions or professional alliances.

The Future Search model is grounded on the principle that all participants must not only have authority, information, expertise, resources, and/or need but also reflect the range of gender, age, culture, and perspectives on the topic. It was precisely the delegates’ diversity that led to transformative relationship building and innovative visioning. For example, an Ivy league, obstetric academic and a self-identified, low-income, single-mother-community activist—two delegates from two totally different worlds—discovered common ground in their commitment to caring for specific populations (substance abuse and homeless women) for whom the conditions required for planned home birth are very difficult to achieve or even dream of. Yet, they agreed that many components of care provided as part of planned home birth would improve the potential for health of their patients.

The consensus statements developed at the summit indeed are phrased as lofty principles that, on first glance, may seem obvious: facilitating interprofessional education, collaboration, and communication; providing appropriate access to highly qualified and regulated providers, regardless of birth setting; addressing the need for tort reform; reducing health-care disparities; improving data collection; and so on. However, all summit delegates acknowledged that applying these principles with tenacity, regardless of birth setting, may prove to be challenging. Because achieving consensus in this process does not mean unanimity, everyone was willing to endorse these statements as written for the larger good of representing the common ground that the delegates discovered. Outstanding questions and issues that could not be addressed in this forum (e.g., debate on the state of the science and tort reform) formed the basis for new initiatives that will focus ongoing dialogue and action on those areas.

Four of the consensus statements are of particular interest and importance to mothers and families and, hence, to childbirth educators and advocates. These statements were proposed and ratified not just by the delegates who represented consumers but by all individuals who attended the summit and were

For more information about the Future Search method, applications, and origins, visit the website of the Future Search Network (www.futuresearch.net).

Visit the website of the Home Birth Consensus Summit (www.home-birthsummit.org) for more information about the attending delegates, the nine consensus statements, and details on next steps.

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themselves mothers, fathers, and family members of childbearing women.

We uphold the autonomy of all childbearing women. All childbearing women, in all maternity care settings, should receive respectful, woman-centered care. This care should include opportunities for a shared decision-making process to help each woman make the choices that are right for her. Shared decision making includes mutual sharing of information about benefits and harms of the range of care options, respect for the woman's autonomy to make decisions in accordance with her values and preferences, and freedom from coercion or punishment for her choices.

We are committed to an equitable maternity care system without disparities in access, delivery of care, or outcomes. This system provides culturally appropriate and affordable care in all settings, in a manner that is acceptable to all communities.

We believe that increased participation by consumers in multistakeholder initiatives is essential to improving maternity care, including the development of high-quality home birth services within an integrated maternity care system.

We recognize and affirm the value of physiological birth for women, babies, families, and society and the value of appropriate interventions based on the best available evidence to achieve optimal outcomes for mothers and babies.

Enlisting the community of recipients of care in creating a vision for the future of maternity care will be essential to realizing the dream, ensuring pragmatic application of the summit's proposed principles within existing health-care systems, and providing accountability. Guidelines for ensuring smooth transfer from planned home birth to hospital, when necessary, must include guidelines for behavior of all health professionals when interacting with families as well as equitable and site-specific rates of compensation for both patients and all providers involved. Physiological birth can only be preserved if the health benefits are made clear to both providers and the public. This will require changes in curricula, in media portrayal

of birth, and in widespread dissemination of emerging information about the neurophysiology of birth and impact of obstetric intervention.

Consumers are best positioned to contribute to a knowledge translation plan that is relevant across cultures and communities. They are also the experts on the nature of health provider–patient interaction that is experienced as respectful and empowering. Most important, no one is more concerned about the neonates' health than the parents. This has been shown to be true even when mothers are disenfranchised by high-risk behaviors or economic status (Racine, Motz, Leslie, & Pepler, 2009). Discussions about the conflict between autonomy and rights of mothers versus the autonomy and rights of babies cannot be done without families participating in the conversation. It is time to widen the circle and create effective networks of experts in each of the priority areas.

There are, of course, topics still in contention: the ethics of autonomy and informed choice in maternity care, the impact on neonatal well-being of birth place and birth procedures, the quality and generalizability of the evidence on safety, and the evidence on best practice for collaboration across settings and professions. These topics were front and center in the conversations at the Home Birth Consensus Summit and were brought to the table by consumers, obstetric professionals, and researchers from the Centers for Disease Control and Prevention, alike. The summit's delegates included at least 25 well-respected quantitative and qualitative researchers who felt strongly about the importance of evidence-based practice. Next steps will naturally include a different kind of consensus conference: exploring the state of the science and creating a relevant research agenda based on gaps that still exist. Simultaneously, acknowledging the voices of women, by addressing ethical issues and prioritizing community-based participatory research, will be essential to the design of research that leads to evidence-based health policy. However, if we allow dissension or anxiety to overtake the momentum we created, then we will be forgetting the primary shared commitment we discovered and affirmed: to work together in service of mothers and babies.

In reflecting on the dialogue and the seriousness of the work started at the Airlie Center in Warrenton, Virginia, and to avoid the impression that the overarching consensus statements were all that was achieved, it is important now to disseminate information about both the summit proceedings and the ongoing work on action plans and initiatives. The work will also not

be credible or effective over time without transparency. Fortunately, following the summit, the Transforming Birth Fund of the New Hampshire Charitable Foundation renewed its commitment with a grant to support follow-up activities. In order for the delegates to continue work on the initiatives identified at the summit, they need ongoing networking tools to be in place. The plan is to build a comprehensive communications structure that includes teleconferencing and video-conferencing and embeds an online forum for discussion and file sharing into the summit's website.

Systems and staff should also be able to support wider community engagement and volunteer coordination. There were many invited delegates who indicated interest in participating in this project yet were unable to attend the summit. In addition, other organizational partners and experts, from both professional and public sectors, will likely engage in these initiatives and expand the multistakeholder and stakeholder-specific working groups. Long-term projects will need the passion and tenacity that certain maternity care providers and parents share. Consumers, educators, and birth advocates can help to widen the circle, identify communications experts, lead individual projects, or serve as advisors. The time is ripe and the possibilities are palpable.

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