Home Birth

FACTS, BIASES AND LIABILITY

Katrina Kilroy, RM

Mount Sinai Hospital

President, Association of Ontario Midwives

Goal

- to raise awareness about the practice of home birth in Ontario, the relevant research literature and address common misconceptions and questions about home births

Participants will learn about

- Professional association position statements and governing body standards and regulations relevant to home birth
- Findings and limitations of the current research about home birth
- Reasons why women and families choose home birth
- Roles and responsibilities during transfer from a home birth into hospital

The Place of Home birth in our Maternity Care System

- In 1987 the Task Force on the Implementation of Midwifery in Ontario addressed the question of how the Ontario health care system should respond to the growing interest in home birth.
- They documented a consensus between the professions that if women choose home birth, they should be attended by well educated midwives who have access to hospital if complications arise.

Eberts M, Edney R, Kaufman K, Schwartz A. Task Force on the implementation of midwifery in Ontario. Ontario Ministry of Health; 1987.

The Place of Home Birth in our Maternity Care System

- Current Canadian and international research supports the safety of home birth for attended, appropriately screened populations
- Outcomes show it to be at least as safe as hospital birth with lower rates of intervention

The Place of Home Birth in our Maternity Care System

- Midwives are required by their College to provide care to women choosing home birth.
- Midwives are insured to provide this type of care
- What is the responsibility of other members of the health care team and what issues of liability does this raise?

Ontario Stats

- Since legislation of midwifery in 1994, there have been approximately 28,000 planned home births attended by registered midwives.
- Currently there are about 2,500 per year, representing <2% of the births in the province and 24% of midwifery attended births.

OMCEP

- Midwives in Ontario, as in the UK and most European countries, are required by standards and regulation to attend women in the birth place of their choice, after careful screening and education about potential limitations and risks as well as the benefits.
- Models of care that include midwives in inter-professional groups need to address this responsibility.

Maternity Care in Ontario 2006: Emerging Crisis, Emerging Solutions, Ontario Maternity Care Expert Panel

SOGC

- Stresses the importance of choice for women and their families in the birthing process.
- Recognizes that women will continue to choose the setting in which they will give birth.
- The SOGC endorses evidence based practice and encourages ongoing research into the safe environment of all birth settings.

SOGC Policy Statement

- All women should receive information about the risks and benefits of their chosen place for giving birth, and should understand any identified limitation of care at their planned birth setting.

Society of Obstetricians and Gynaecologists of Canada. Midwifery. SOGC Policy Statement No. 126, 2003 Mar.

CPSO

- Policy against home birth from 1994 until 2001
- Now states home birth for low-risk women is a viable, if not widely practiced option.
- A review in 2001 stated a need to recognize the scientific literature indicates that there is no compelling evidence either supporting or opposing planned home births for low-risk patients.

College of Physicians and Surgeons of Ontario. Members Dialogue. March/April '01

ACOG

- Feb 2008 statement on home births recommends that all women “deliver their baby in a hospital, hospital-based birthing center, or properly accredited freestanding birth center.”
- ACOG acknowledges a woman's right to make informed decisions regarding her delivery and to have a choice in choosing her health care provider, but ACOG does not support programs that advocate for, or individuals who provide, home births.

American Medical Association

- Supports the recent American College of Obstetricians and Gynecologists (ACOG) statement.
- “believes that obstetrical facilities and their staff should recognize the wishes of women and their families *within the bounds of sound obstetrical practice*.” (emphasis added)

AMA Policy: H-420.998 Obstetrical Delivery in the Home or Outpatient Facility

RCOG and RCM

- “support home birth for women with uncomplicated pregnancies. There is no reason why home birth should not be offered to women at low risk of complications and it may confer considerable benefits for them and their families. There is ample evidence showing that labouring at home increases a woman’s likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby.”

Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, Joint statement No.2, April 2007

Outcomes Associated with Planned Home and Planned Hospital Births in Low-Risk Women Attended by Midwives in Ontario, Canada, 2003–2006: A Retrospective Cohort Study

Eileen K. Hutton, PhD, Angela H. Reitsma, BSc, BHSc, and Karyn Kaufman, DrPH.

BIRTH 36:3 September 2009

Outcomes

- Primary outcome measure was maternal mortality or serious morbidity
- Secondary outcome was neonatal or perinatal mortality or serious morbidity
- Reduced intervention rates in the planned home birth group

Outcomes

- women planning a home birth were less likely to experience serious morbidity (5.5%) compared with women in a hospital group (7.1%), for a relative risk of 0.77
- no statistically significant difference in secondary outcome measures between the home and hospital groups, with 2.4% at home and 2.9% in the hospital group RR 0.83 [0.67, 1.02]

Outcomes

- Transfer rate of 22%
- Ambulance transfer rate of 5%
- C-section rates - 3% reduction for planned home births

Outcomes of planned home birth with registered midwife versus planned hospital birth with midwife or physician

Patricia A. Janssen PhD, Lee Saxell MA, Lesley A. Page PhD, Michael C. Klein MD, Robert M. Liston MD, Shoo K. Lee MBBS PhD

CMAJ 2009. DOI:10.1503/cmaj.081869

Study Design

Study Group

- All births planned (at the onset of labour) to be at home and attended by a regulated midwife, n = 2899

Comparison Groups

- Physician-attended births in hospital n = 5331
- Midwife-attended births planned (at the onset of labour) to be in hospital n = 4752 (same midwives)

Outcomes

Compared to women who planned birth in hospital with a midwife or physician, women who planned birth at home with a regulated midwife were:

Less likely to have interventions during labour

Less likely to have adverse maternal outcomes:

- 3rd/4th degree tear
- Postpartum hemorrhage
- Pyrexia
- Infection (MD group only)

Outcomes

Home birth group was also less likely to have newborns with:

- Meconium aspiration (mw hosp group only)
- Birth trauma
- Resuscitation at birth
- Requirement for oxygen therapy more than 24 hours
- More likely to have newborn admitted to hospital (MW hosp group only)

Perinatal mortaility and morbidity in a nationwide cohort of 529 688 low-risk planned home and hospital births

- To compare perinatal mortality and severe perinatal morbidity between planned home and planned hospital births among low-risk women who started their labour in primary (midwifery) care.

de Jonge A, van der Goes B, Ravelli A, Amelink-Verburg M, Mol B, Nijhuis J, Bennebroek Gravenhorst J, Buitendijk S. BJOG 2009; DOI: 10.1111/j.1471-0528.2009.02175.x.

- A total of 529 688 low-risk women who were in primary midwife-led care at the onset of labour. Of these, 321 307 (60.7%) intended to give birth at home, 163 261 (30.8%) planned to give birth in hospital and for 45 120 (8.5%), the intended place of birth was unknown.
- Primary outcome measures were intrapartum death, intrapartum and neonatal death within 24 hours after birth, intrapartum and death within 7 days and neonatal admission to an intensive care unit.

Results

- No significant differences were found between planned home and planned hospital birth (adjusted relative risks and 95% confidence intervals): intrapartum death 0.97 (0.69 to 1.37), intrapartum death and neonatal death during the first 24 hours 1.02 (0.77 to 1.36), intrapartum death and neonatal death up to 7 days 1.00 (0.78 to 1.27), admission to neonatal intensive care unit 1.00 (0.86 to 1.16).

Conclusions

- This study shows that planning a home birth does not increase the risks of perinatal mortality and severe perinatal morbidity among low-risk women, provided the maternity care system facilitates this choice through the availability of well trained midwives and through a good transportation and referral system.

Wax JR, et.al. Maternal and newborn outcomes in planned home birth vs planned hospital births: a meta analysis.
AJOG Volume 203, Issue 3 September 2010, Pages 243.e1-243.e8

Meta-analysis found that neonatal death rate is 3 times higher for home birth than hospital birth, though no difference in perinatal death rate

Criticism of Wax Study

- Inclusion of faulty data sets, combining high and low risk, unintended and unattended homebirths
- Studies like this deepen the mistrust on both sides between midwives and other health care workers
- After removing low-quality studies and out-of-date statistics, study demonstrates no difference in outcomes between home and hospital-based delivery, even for neonatal mortality.

Limitations of the research

- No RCTs
- Would it be ethical?
- It appears that home birth and hospital birth are about equally safe (perhaps equal but different)
- Or, there is a difference that we haven't found yet
- Or, there is a selection bias

Biases

- Having a baby at home is dangerous and/or selfish
- “They” do things differently
- Training is poor/judgment is poor
- Midwives expect doctors to “clean up their messes”
- Doctors are too interventive
- Home is better than hospital/hospital is better than home
- “Good thing this wasn’t a home birth”

Who are these women?

- Women who choose home birth are less risk averse.
- Some women may be alienated by hospital environment for a complex set of personal reasons and experiences.
- It is our job to serve them…midwives in attendance and hospitals to back us up

Who are these midwives?

- Highly trained
- Required by College of Midwives to offer choice of birthplace
- Best practice for midwives internationally is to offer low intervention approaches to care supported by the evidence

What happens if?

- NRFHR: auscultation and transfer if persistent concerning pattern or EFM needed. Fluids and O_2 available for intrauterine resuscitation.
- Particulate meconium: transfer if birth not imminent. Suction and resuscitation equipment available. Intubation currently not available.
- PPH: midwives carry oxytocin, ergot, hemabate, IV supplies and O_2.

- NRP: midwives carry O_2, bag and mask and self-inflating or flow inflating bags and are certified annually in NRP.
- Other emergencies: shoulder dystocia, placental abruption, cord prolapse, undiagnosed breech
- Midwives are trained to manage emergencies until able to transfer to medical care as appropriate
- Required to re-certify in emergency skills every two years (ALSO, ALARM, MOREob or AOM ESW)

Home Birth in Context

- Home birth in most parts of the province meets the Ontario standard of access to an emergency C/S within 30 minutes
- Availability of hospitals and transfer helps keep home birth safe

Liability

- Hospital practitioners are not responsible for the care provided by the midwife prior to admission to the hospital
- Greatest risk arises where there is poor communication

Fear of Liability

- Much misunderstood
- CMPA/HIROC joint statement on physicians and midwives working together
- Midwives carry adequate liability insurance and are covered in the same way for home and hospital birth

Liability Protection

Canadian Medical Protective Association (CMPA)

Healthcare Insurance Reciprocal of Canada (HIROC)

Physicians

Health care organization

Employees

Midwives

Association of Ontario Midwives

Legal Actions

- Midwifery is a young profession
- One legal case involving planned home birth (prelegislation and about ECV not birthplace)

Reducing Liability - Hospital Staff

- When a midwife calls in with a home birth transport on the way, trust her assessment and respond
- Call in on-call staff
- Build an environment of trust and open communication
- A respectful and efficient reception in hospital is a very important component of safety and the ethical thing to do

Reducing Liability – Hospital Staff

- Have a clear process to analyze near-misses and adverse events involving home birth transport
- Leadership is important – ongoing education for all staff about midwives, their role in home birth and home birth transfers can reduce misunderstanding, fear and miscommunication
- Poor relationships increase liability - conveying respect for parents' choice to attempt home birth helps build a positive relationship with the parents

Reducing Liability – Systems Issues

- Importance of support for midwives to use judgment about where to transfer – directing EMS to closest hospital or hospital where midwife has privileges
- Importance of supporting midwives to follow national standards at home births eg. Offering GBS prophylaxis
- Respect for midwives' full role in hospital supports best practice at home births

Reducing Liability - Midwives

- Communication must be clear, concise and upfront
- Be familiar with hospital protocols and prepare client appropriately
- Support consultant's advice
- Participate in process to analyze near-misses and adverse events involving home birth transport

Questions?