ACEO *Statement of Policy*

As issued by the ACEO Executive Board

OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES

Seventy percent of the childbearing population in the US is healthy and enjoys a normal pregnancy. For this population, labor and delivery is a physiologic process that most women experience without complications.[1] Physiological management of normal childbirth is the science-based model of care for healthy women who are experiencing a normal pregnancy. [2] *Physiological* is defined by Stedman's Medical Dictionary as "*in accord with, or characteristic of, the normal functioning of a living organism*". It is the standard used worldwide by family practice physicians, midwives and obstetricians in countries that achieve better maternal-infant outcomes at much less expense than the US. [2, 3]

The principles of physiological management are both *preventative and protective.*[4] They are associated with the *lowest* rate of mortality and morbidity for both mothers and babies; its methods are also *protective* of the mother's pelvic floor. It is both *safe and cost-effective,* with a cesarean rate as low as 4%. [5] To achieve such good outcomes, birth attendants providing physiological care are careful not to disturb the natural process and to minimize technological interventions. [6] This model of normal childbirth includes monitoring the physical, psychological and social well-being of the mother via continuous hands-on assistance during labor and delivery. Women who require medical attention are identified and referred to the appropriate specialist.

Normal management of childbirth emphasizes informed choice, continuity of care, patience, social and emotional support, maternal mobility and upright positions, non-drug methods of pain relief and the right use of gravity. The positive influence of gravity, in combination with maternal mobility, stimulates labor, dilates the cervix and helps the descent of the baby through the bony pelvis. [7,8,9,] This not only assists the biological process, but also diminishes the mother's perception of pain, perhaps by stimulating the release of endorphins [10]. Obstetrical intervention is reserved for complications or at the mother's requests.

Due to a historical bias in medical training in the US, [11,12,13,14,15] only professional midwives are currently being trained to provide physiologic care. As a result, the physiological management of normal childbirth in the US is only available in *out-of-hospital settings* – independent birth centers and planned home birth. The decision by healthy childbearing women with normal pregnancies to labor at home or in free-standing birth centers is a responsible choice amply supported by the scientific research. When labor progresses normally, it is as safe to give birth in an out-of-hospital setting as it is in a hospital. [3,5,6,16,18]

Healthy women do not normally benefit from the popular system of interventionist obstetrics known in the US as the "*obstetrical package*". [17,18,19] These hospital-based protocols include drastically increased rates of drug and anesthetic use, episiotomy, instrumental delivery (associated with stress incontinence), and cesarean surgery. [20,] High rates of obstetrical intervention are associated with greater frequency and severity of complications, including delayed and downstream problems in future pregnancies. [21-26] When the obstetrical package is applied routinely to healthy women with normal pregnancies*,* as it is in the US, it provides the *opposite* of evidence-based care.

Nonetheless, the obstetrical profession remains convinced that immediate availability of obstetrical expertise and interventions associated with planned *hospital* birth is an important component in saving the life of mother, fetus or newborn and reducing the likelihood of an adverse outcome. Unfortunately, the lack of obstetrical support for normal biology, paired with the excessive use of obstetrical interventions in hospital birth (often the result of practicing 'defensive medicine') introduces such a high rate of iatrogenic complications that any potential advantage is eliminated and the rate of complications for healthy women is actually increased two to tenfold [5,6]. The obstetrical package for a *healthy* population – including the elective use of cesarean – is ***not healthier, safer, cheaper or better for society*** than physiologic birth. [18-26]

For these reasons, the American College of Evidence-based Obstetrics (ACEO) believes that the hospital, including a birthing center within a hospital complex, is NOT the safest setting for labor, delivery and the immediate postpartum period. The only exception to this is for women who are planning to receive labor stimulants, narcotic pain medications and/or anesthetics, and thus will need and benefit from medicalized care. As currently practiced, obstetrics is an 'expert' system that has failed *most* in the very area it was supposed to have the *most* mastery and expertise -- preserving the health and well-being of already healthy mothers and babies. [18,19,20]

Until the time-tested principles of physiological management are incorporated into medical training and the obstetrical profession routinely utilizes physiological management when providing care to healthy women, the **ACEO strongly opposes hospital births for healthy women.** However, ACEO supports providing conditions that will improve the childbirth experience for women and their families without compromising safety, regardless of the setting chosen by the mother or required by necessity.

As noted throughout this policy statement, studies comparing safety, intervention rates and outcomes of planned *hospital* births with *planned home and birth-center* births have been scientifically rigorous in nature and abundant in number. It is the consensus of the scientific literature that planned home birth and independent birth center births are associated with safety, good outcomes and cost-effectiveness, with significantly reduced rates of medical and surgical intervention, operative delivery and subsequent complications. California studies suggest that low-risk women who choose a physiologically managed birth in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to the hospital. [6, 26]

The development of additional well-designed studies of sufficient size, prepared in consultation with professional midwives and other birth attendants trained and skilled in physiological management, might further clarify the comparative safety for births managed under these dramatically different styles. This would lead to the reform of our national maternity care policy by integrating the principles of physiological management with the *best advances in obstetrical medicine* to create a single, evidence-based standard for all healthy women. Physiological management should be the foremost standard for all healthy women with normal pregnancies, used by all practitioners (physicians and midwives) and in all birth settings. [28]

Although ACEO acknowledges a woman's right to make informed decisions regarding normal birth, the ACEO questions the ethics and efficacy of exposing healthy women with normal pregnancies to the iatrogenic and nosocomial component of the obstetrical package and the added expense of associated complications. Until such studies are able to establish beyond a reasonable doubt that the obstetrical package is no longer a vector for iatrogenic complications in healthy childbirth, the ACEO must continue to oppose hospital-based maternity care for normal childbirth. For that reason, ACEO does not support programs or individuals that advocate for or who provide hospital birth services that impose the protocols of interventionist obstetrics on healthy women with normal pregnancies.

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