April 17, 2014

To: ACNM Members

The following is ACNM's statement in response to an article that has been accepted for publication by *American Journal of Obstetrics and Gynecology (*AJOG), entitled "Early and Total Neonatal Mortality in Relation to Birth Setting in the United States, 2006-2009."

Neonatal mortality is a significant concern for all professionals providing care to women and newborns. Studies that can legitimately and accurately expand the body of knowledge in identifying and addressing causes of infant mortality deserve our attention. While this AJOG article provides some interesting directional data, several significant concerns with its data and methods undermine the conclusion that health care professionals have a responsibility to "advise against home births."

First, there are serious questions about the accuracy of the vital statistics data upon which this study is based. Birth certificates are not always completely filled out, nor are they always filled out by the provider attending the birth. The data are not always accurate, when compared to medical charts filled out by the attending provider. (See this study from the CDC for further reference: http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_02.pdf).

The study depends on these data for its results. For example, the authors included in their study singleton births (37+ weeks and newborn weight ≥ 2500 grams) without documented congenital malformation by birth setting and provider. Inaccuracies in the birth certificates upon which the study is based would necessarily result in inappropriate inclusion or exclusion of births.

Additionally, it is not possible to determine, from the birth certificate data, who the woman intended to receive care from, the intended location of birth, nor is it possible to follow intrapartum transfer information from home to hospital.

Further, the birth certificate data do not allow researchers to accurately separate out planned vs. unplanned home births. We know that mortality rates are higher for unplanned home births, as they are more likely to involve emergency or urgent situations. The inability to distinguish between the two casts doubt on the findings.

All birth certificates also have a field for specifying whether a birth was attended by a "CNM/CM" or "other midwife." There is no way to determine the credentials, education, or licensure status of a person referred to as "other midwife."

The data in the article show that across all cohorts of patients, midwife-attended hospital birth is associated with the lowest rates of neonatal mortality, lower in every instance than that of physician-attended hospital birth. The authors surmise that this is due to "the fact that hospital physicians deliver a higher-risk population than hospital midwives and deliver patients with complications transferred from the hospital midwifery service to the hospital physician service." Unfortunately, the data with regard to the population of patients attended by each provider type are not risk adjusted, so we do not know whether this statement is correct. Likewise, without risk adjustment for patients delivering in

each of the studied locations, we do not know true comparative risks of neonatal mortality by birth setting or by provider type.

Because ACNM takes the safety of mothers and babies very seriously, we appreciate the authors' efforts to investigate an important topic. Unfortunately, studies rooted in unreliable data and methods do not facilitate these activities. Women, families and providers need clear, reliable, accurate data in order to make shared decisions about birth setting. Professional organizations also need and welcome this information when it affects care provided by their members. A study of nearly 17,000 planned home births, based on the MANA dataset and published recently in the *Journal of Midwifery and Women's Health*, found that that the vast majority of women who had planned home births had good outcomes – both for themselves and their babies. This study was based on the more reliable, comprehensive medical records of the attending providers, not on birth certificate data. ACNM encourages researchers to take this approach when studying home birth in the future, as randomized controlled trials, the gold standard for clinical research, are infeasible for this purpose.

Finally, ACNM affirms women's right to select the setting and provider for their birth. Some women will always choose to give birth in their homes. ACNM believes it's important to focus on a seamless, integrated process for transfer of care so that women who have chosen, and will continue to choose, a home birth setting for childbirth have access to the appropriate level of safe, respectful care at all times. ACNM has endorsed the newly developed *Best Practice Guidelines: Transfer from Planned Home Birth to Hospital*, a resource to assist maternity care providers and other professionals to better support a seamless transition when transfer of care is necessary. The guidelines were developed in a spirit of inter-professional collaboration, promoting open communication and education, review and reflection in the interest of quality and safety and respectful, responsive care centered on women and families. Through the use of these model guidelines, we believe care will be improved, systems of communication will be enhanced and mothers and babies will have a better opportunity for optimal health outcomes overall.