The Value of Giving Birth at Home:

Susan Stark
Bates College

Introduction

Issues in reproductive ethics continue occupy us, both in public policy and in bioethics. Questions about the ethics of voluntary pregnancy terminations are front and center, and this trend is likely to continue for some time, as public discourse continues to be sharply divided on this issue. But lately, reproductive ethics has included a wider range of issues, including questions about the ethics of cesarean delivery on maternal request (CMDR),[1] concerns about the injustice of racial disparities in state intrusions into parenting,[2] and also questions about the moral permissibility of giving birth at home. The last issue shall be my focus.

A small, but committed number of people give birth at home in the United States and abroad[3] every year. In the United States in 2011, there were about 25,000 births in the home, where 75% of these were planned home births. There are some indications from the Centers for Disease Control and Prevention that the percentage of people giving birth at home is increasing, from .56% of all births in 2004 to .72% of all births in 2009 and 1.4% (or 50,000) of all births in 2012.

Hospital births, had by the overwhelming majority of people who give birth, and certainly needed by some of these people, nonetheless do not meet then needs of all who give birth. When compared to home births, hospital births have higher rates of morbidity and

---

[1] Kukla et al, “Finding Autonomy in Birth,” 2009.
[2] Cite that feminism article…
[3] Cite the NPR story on “Morning Edition,” regarding homebirth in Mexico. September 13, 2017.

mortality[4] for birthing mothers;[5] as a matter of individual psychology, hospital births are not desired by all who give birth; and as a philosophical issue, hospital births may contribute to disempowering people who give birth there, whereas homebirths may empower them.

Now certainly, some people who give birth need to do so in a hospital. According to an analysis by the Journal of the American Medical Association, the ideal rate for cesarean section births appears to be about 19%, in order to optimize outcomes for birthing mothers and babies,[6] and the US Department of Health and Human Services has set a cesarean section birth target of 23.9% by 2020.[7] And even beyond this cesarean section rate, the sciences of obstetrics and perinatology are not yet advanced enough to accurately predict who, in early labor or prior to the onset of labor, will need a cesarean section or some other intervention to safeguard the health of the birthing mother and or the baby. So it is likely that more than 20% of births need to take place in hospitals.

Some birthing mothers no doubt also feel more comfortable giving birth in the hospital. For at least some of these individuals, it may be best for them to give birth in the hospital. At the same time, however, many people already desire an out-of-hospital birth (either at home or in a freestanding birth center[8]) and many others might, with more information about birthing

---

[4] Wax, et al…

[5] I will use the terms “birthing mothers” and “people who give birth” interchangeably, with the full recognition that “birthing mothers” and “people who give birth” can refer to people of any gender identity.

[6] https://www.statnews.com/2015/12/01/cesarean-section-childbirth/

[7] https://opinionator.blogs.nytimes.com/2016/01/19/arsdarian-cutting-the-number-of-c-section-births/

[8] A free standing birth center is a birth center that is not affiliated with or governed by any hospital.

options, and so for these individuals, the ethics of homebirth is a live, important, and timely question.

Much of the medical and philosophical literatures on homebirth have focused on the safety of giving birth outside of a hospital.[9] Determining the safety of giving birth in the home is partly an empirical matter that can be elucidated by data on birth outcomes in the home and in the hospital. But whether it is safe for a particular family to give birth at home is also a philosophical matter that depends on one's attitudes toward risk and on one's views of the goods that can be secured through giving birth in different locations.[10] In what follows, I focus first on safety and attitudes toward risk and then on the values that might be promoted through giving birth at home (versus in the hospital).

Regarding the empirical matter of birth outcomes, unfortunately, excellent data on homebirth outcomes has been elusive. To date, there have been no large-scale randomized clinical trials of planned home birth. And given that most people have clear and strong preferences about where to give birth, it is difficult to imagine that large numbers of people giving birth could be persuaded to enter a randomized clinical trial and be randomly assigned a place of birth. For that reason, I assume the validity of the best data we currently have on home birth. While it might be instructive to have more data, or better data, my argument will not rely on the assumption that this data will be forthcoming.

The data[11] we have on home birth outcomes currently suggest that people who give birth in hospitals receive more interventions during labor (including epidurals, electronic fetal

[9] Journal of Clinical Ethics articles, 2013.
[10] This point is also made by Kukla et al in their article on CDMR.
[11] Wax et al.

monitoring, episiotomy, operative vaginal deliveries, and cesarean deliveries); people giving birth in hospitals have a modestly increased incidence of most morbidities (greater than third-degree laceration, infection, cord prolapse, retained placenta) – though people giving birth at home have a greater incidence of perineal laceration and a similar incidence of postpartum hemorrhage. And while newborns have similar or lower incidence of morbidity when born in a planned home birth, newborns born at home have a higher incidence of death (in the meta-analysis by Wax, et al, there were 32 deaths in 16,500 births at home, whereas there were the same number of deaths (32) in more than twice as many hospital births (33,302)). Given the data we currently have, there appears to be a risk of death twice as high for newborns born at home as for those born in the hospital.

Home birth, like many other questions in reproductive ethics, appears to pit the well being of the birthing mother against the well being of the newborn. Precisely as a result of this perceived tension, some have argued against planned home birth. Some policy makers and medical professionals for instance, have argued that health care providers (be they physicians, nurse-midwives, or professional midwives) should neither recommend nor be involved with home births. Some have gone further to suggest that it is contrary to the tenets of these professions ("unprofessional") to in any way support home birth.[12] Some members of the public may hold this view as well. Some arguments are also directed at birthing mothers: the idea that giving birth at home subjects one's infant to a twice higher risk of death strikes many as irresponsible, unconscionable, "unmotherly." It appears to value a more pleasant experience (a birth at home) over the life and well being of one's child. Many hold the view that it shouldn't

[12] Cite Cheverniak in Journal of Clinical Ethics.

matter where one gives birth; all that matters is the outcome: a healthy mother and a healthy baby. While this view may be rational, I argue in what follows that it is not the only rational view to hold on the geography of giving birth.

I believe that it is reasonable to assume that giving birth at home may be more risky than giving birth in a hospital. Of course given the way birth is managed in US hospitals, those births are subject to risks that those who give birth at home do not face (a higher rate of medical interventions and a higher than recommended rate of cesarean sections for instance). But even if birth could be managed according to best practices in the hospital and at home, still one would suspect that home birth might be inherently more dangerous than hospital birth: complications in childbirth can arise without any warning and in these cases, it will always be more dangerous to be farther away from an operating room. Ten or twenty minutes, can, in rare instances, result in the difference between life and death, or between health and morbidity. So it is reasonable to suppose that even in their Platonic ideals, giving birth at home might always be somewhat more risky than giving birth in a hospital.

But even if there is some inherent risk to giving birth at home, I shall advance two arguments in favor of planned home births: first I argue that the dangers posed by homebirth (recall that these are predominantly to babies) are well within the reasonable range we allow parents to make in other spheres of their parental lives including mundane matters such as driving, playing sports, and going swimming. Moreover, in other spheres of parenting, we grant parents the freedom of bodily autonomy, even when upholding this value endangers the life of, or results in, the death of the child. Second, I argue that the choice to give birth at home embraces a number of important values: giving birth at home is an acknowledgment of the,

often unrecognized, role of passivity in human life.[13] Giving birth at home requires a kind of agency within passivity, a reliance on the self, and a recognition of the inherent chanciness of life.[14] These goods are not easily achieved in, or perhaps antithetical to, a hospital birth; as a result, giving birth in a hospital represents a lost opportunity to cultivate these virtues that support individual well being.

I conclude by considering two objections to my view. The first objection holds that much of this argument seems to focus on the autonomy of parents, the good of the birthing mother, seemingly to the exclusion of the well being of the baby. I argue that the conflict is only an apparent one: that it is more accurate to think that in most cases, the well being of babies and children is promoted when the autonomy of their parents is supported. Finally, I address the issue that home birth has largely been an issue for white, straight, cis-gendered, middle and upper-middle class women. Brown and black women, trans people, gender queer people may seem to be erased or overlooked just in virtue of having this debate. Here, I argue, drawing on work by Oparah,[15] that home birth with a supportive birth attendant can be an empowering experience for people of all races, genders, identities, and backgrounds.

Before I consider the matter of safety, I have one final caveat: one might think that this debate rests largely on convenience. On some views, what is important is the ease of remaining at home, or the inconvenience of having to travel during the process of childbirth. While these considerations are important to some people, the focus of my concern is not precisely this.

---

[13] Building upon the argument made by T. Staehler in Medicine, Health Care, and Philosophy, 2016.

[14] Here I build upon an argument in B. Halfdansdotter, Medicine, Health Care and Philosophy, 2015.

[15] Julia Chinyere Oparah, Birthing Justice….

Rather my focus is primarily on the cultural norms that abide in hospitals versus those that abide in out-of-hospital births. The latter empower people giving birth, the former do not. Or so I shall argue.

Safety First?

We have seen that being born at home birth appears to subject babies to twice greater risks of death. Some argue that this fact alone should lead us to avoid home birth as long as this outcome disparity exists. To consider whether this is true, we begin outside of the often heated, highly contested domain of pregnancy and childbirth, as I believe that our views about pregnancy and childbirth are often inconsistent with views we hold in other domains of life. Consider the following examples:

According to the CDC, between 2005 and 2009, approximately 700 children younger than 14 died **every year** from non-boating related drownings. Most of these drownings occurred in home swimming pools. Drowning is the second leading cause of death in children aged 1-4 (after congenital anomalies).[16]

A different example: in 2013 alone, there were 8 fatalities among high school students while playing organized football. From 2000-2013, there were a total of 47 deaths of high school students while playing football. These deaths are due to overheating, heart conditions, and traumatic brain injury.[17]

---

[16] http://www.cdc.gov/homeandrecreationalsafety/water-safety/waterinjuries-factsheet.html.
[17] http://www.bloomberg.com/news/2014-10-10/texas-dad-prays-as-high-school-football-faces-deaths.html

In 2003, there were more than 2100 traffic fatalities in children younger than 14. Though some were alcohol-related, nearly 80% of these children died in non-alcohol related crashes. Moreover roughly 45% of these children were properly restrained with seat belts and child safety seats.[18] This means that nearly 1000 children are killed every year in traffic fatalities where those accidents are neither the result of improper seat restraint nor of someone operating under the influence.

In 2003, there were 390 pedestrian fatalities in the US in children aged younger than 14, and 130 bicycle fatalities in children under age 14. Approximately 15% of those fatalities (19 people) were children who were properly wearing bicycle helmets.[19]

In 1987, Congress allowed the rural speed limit to increase beyond 55 miles per hour; then in 1995, Congress repealed the federal speed limit of 55 miles per hour. As a result, many states increased their highway speed limit to 65 MPH, others to 70 MPH and still others to 75 MPH. In 1987, following the increase of the rural speed limit, there were 15% more deaths on rural highways than during the preceding five years.[20] During the period from 1995-2005, following the repeal of the federal speed limit, highway fatalities increased by more than 12,500 deaths, and this despite significant improvements in automobile safety, including better seatbelts, front and side air bags and so on and better trauma care.[21]

---

[18] NHTSA.
[19] Ibid.
[20] *American Journal of Public Health,* October 1989, Vol. 79, No 10.
[21] Leslie M. Beitsch and Liza C. Corso. Accountability: The Fast Lane on the Highway to Change. *American Journal of Public Health*: September 2009, Vol. 99, No. 9, pp. 1545-1545; also reported in The New York Times: http://www.nytimes.com/2009/07/21/health/research/21safe.htmlNY Times 2009

Finally, consider the public policy initiative in Stockholm, Sweden, known as Vision Zero: Vision Zero is a series of initiatives in Stockholm to reduce traffic-related fatalities (including car crashes, car vs. bicycle crashes, and car vs. pedestrian crashes) to zero. The initiatives include lower speed limits, more physical barriers, and automated enforcement; together they have cut traffic fatalities in Stockholm in half since their enactment in 1997. The current traffic fatality rate in Stockholm is 1.1 deaths per 100,000, less than one-third the rate of comparably-sized New York City. And although improvements in trauma care have increased the survivability of serious car crashes, states and cities in the US that have adopted Vision-Zero type programs have seen traffic fatalities drop at disproportionately higher rates. The NY Times reports that, "Fatality rates in American states with Vision Zero policies, including Minnesota and Utah, fell at a pace more than 25 percent quicker than the national rate."[22]

What I take these examples to show is that, as a society, we believe it is sometimes rational to prioritize some other value over safety. In the case of swimming pools, for instance, those of us who have swimming pools in our backyards are trading the safety of our children for a kind of experience (the pleasant experience of swimming at home on a hot summer day). We could, at a fairly low social cost, eliminate nearly all of those 700 deaths per year, if we banned home swimming pools (indeed, even requiring a four sided enclosing fence immediately around the pool, rather than around the perimeter of the yard, would go a significant distance toward reducing these deaths).

---

[22] NY Times: http://www.nytimes.com/2014/05/13/nyregion/de-blasio-looks-toward-sweden-for-road-safety.html?_r=0

The same thing is true of driving. Though it is difficult to quantify precisely how many children are killed each year due to an increase in speed limits, it is certainly more than a few children every year. We could, as Stockholm has done, adopt social policies that significantly reduce or even possibly eliminate all traffic fatalities (including deaths in cars, on bicycles, and for pedestrians). But we currently value efficiency and the freedom to drive faster greater than we value these individuals' lives. Indeed, someone even suggested to me that valuing efficiency in this context could be quantified: even if more people die as a result of driving faster, the total benefit to society of permitting faster driving is greater due to the increased productivity and efficiency of those who stay alive. I was unable to confirm this analysis; nonetheless, it suggests that some people find this exchange of safety for efficiency rational and justified.

Something similar can be said of the deaths of the football players: as a society, we are willing to trade those 4 or 8 lives every year, for the pleasure and value of many thousands of other children playing and enjoying football and the enjoyment experienced by their families, friends, and fans watching the games.

My first point, derived from these many examples, is that we, in many domains of life, are willing to trade our children's safety for other goods, including freedom, efficiency, and pleasure. We do this in two ways: sometimes we exchange safety for goods experienced by the children themselves (playing football, swimming in at-home swimming pools); other times we exchange our children's safety for goods that accrue to the adults (or siblings) in the lives of those children: the freedom to drive faster, the increased efficiency of getting to work earlier, or staying home a few minutes longer, or even enjoying a swim at home. In the first kind of case, we are willing to risk the small chance that our child will die playing football (or skiing,

doing gymnastics, or riding a bicycle) for the greater chance that our child will play and enjoy the activity in question. In the second kind of case, we are willing to risk the small chance that our child will die in a car crash or in a swimming pool, for the greater chance that others will enjoy the freedom and efficiency of driving faster or for the greater chance that the whole family will enjoy the swimming pool.

I believe that this trade-off is very similar to the trade-off birthing mothers and families make when they choose to give birth at home. We can even grant the argument of the home birth opponent, namely that people who choose to give birth at home are choosing a certain kind of experience (a birth at home) in exchange for a slightly greater risk of death for their newborn.

Let us consider, then, the parallels between these examples and the case of home birth. As in the example of driving faster, one good that is secured by home birth is freedom: the freedom to give birth in the place of one's choosing, in the way and at the place where one is most comfortable. This good includes a number of other freedoms, including the freedom to eat and drink as one wishes, etc., and the freedom to be free of hospital regulations that are of necessity designed for the majority, but where their particular requirements may or may not benefit an individual birthing mother. Thus in its promotion of freedom, giving birth at home is in this way much like driving: both promote freedom at the cost of a few preventable deaths.

Someone who gives birth at home also aims to avoid a number of harms that are, fairly likely, to result from giving birth in the hospital. In 2012, rates of cesarean birth remained at about 33% of all births (all statistics here from CDC: National Vital Statistics System), and rates of operative delivery (forceps and vacuum extraction) were about 3.5%. Rates of episiotomies

are also much higher in hospitals than in homes. A related phenomenon of hospital birth is the cascade of interventions (from continuous fetal monitoring, to use of labor augmentation, to epidurals to cesarean delivery), where a seemingly-innocuous or even beneficial fetal monitor leads to unnecessary cesarean deliveries. The long term consequences of these interventions is not currently known: these interventions may have harmful long term effects on breastfeeding, parent-infant bonding, on the gut bacteria in infants and the effects of this on the immune system later in life, and on rates of postpartum depression in birthing mothers. Someone who chooses a home birth, chooses to avoid the greater likelihood of these interventions (a 33% chance of a cesarean birth, for instance) and the uncertain downstream consequences of that, in exchange for a slightly higher risk of death to one's newborn. As we have seen, many of us regard it as rational to accept the risk of a very small chance of a very bad event (death of a child in a car accident) for the far greater chance of avoiding a moderately bad event (being late to work). If this exchange of convenience for safety is rational in the case of driving faster, it is hard to see why it is not rational in the case of giving birth at home.

But now some people will react to the examples I have given (of football, swimming pools and driving safety) and argue that we should, as Sweden has, adopt Vision Zero policies all around: we should reduce speed limits, ban home swimming pools, prevent young children from playing football. In short, we should value safety much more highly than we currently do. Just as the loss of one at home swimmer, one child football player, one pedestrian, or one bicyclist, or one motorist is too many, in the same way, the loss of even one neonate is too many, and so we ought to do everything we can to prevent neonatal deaths, and that includes opposition to home birth.

It may be rational to hold this view. But notice that it does not unproblematically point us to the view that home birth is unethical, "unprofessional," or should not be allowed. Rather, it suggests that, first, we should strive to make home birth safer. The current outcomes for out-of-hospital births are not a fixed point in safety. We have not, in the US at least, done everything we can to make home birth as safe as it can possibly be. Currently many well-trained home birth midwives in many states in the US (unlike many of their counterparts in Europe), practice in isolation from obstetricians and the medical community. As a result, there do not exist guidelines for safe home births, clear transfer protocols, and good, supportive, collegial relationships between midwives and obstetricians. To this end, we should foster collaboration between obstetricians and home birth midwives, better regulate home birth midwives, develop clear transfer protocols and regulations on which laboring mothers will be at low-risk for complications during childbirth and thus good candidates for home birth. We should also promote the existence of freestanding birth centers (birth centers not governed by hospital policies but in close geographical proximity to them) because they may be an effective way to provide the home birth experience, but reduce some of the risks of home birth by reducing the time required for a transfer to the hospital.

We should also strive to make hospital birth safer and more appealing, by reducing the number of interventions, by allowing birthing mothers the same freedoms enjoyed by people who birth at home (providing calm, private, aesthetically appealing environments to all laboring people, providing a dedicated and supportive nurse to be at the bedside and offer continuous support during labor). We should strive to bring the rate of cesarean birth in line with the recommendation recently published in JAMA of 19%. We should allow people in labor to have

the freedom of movement and the freedom to give birth in the way that is most natural and comfortable for them. If we do these things, it is possible that hospital birth will be so attractive, with appropriate rates of cesarean birth, freedom of movement in labor, a sacred space for birth, that it might be far less rational in that world, to choose home birth. But until such time, we ought to strive to make home birth and hospital birth as safe and appealing as we possibly can.

One final objection as concerns safety: perhaps the objection to home birth concerns not what risks we should tolerate as a society to protect freedom, efficiency or another good, but rather what we should expect parents to do to save the lives of their children. This is an important point. But I would caution that accepting this view with respect to home birth will have far-reaching consequences: if we require people to give birth in hospitals against their wishes, we must also require parents to drive more slowly (55 MPH for parents?), to remove swimming pools from their backyards, to prevent their children from playing football, riding bikes, and so on. Indeed, we will also need to shift our policies and require that parents donate blood, their extra kidneys, the lobes of their livers to save the lives of their children. We do not currently require any of these things, perhaps because we believe that parents are not required to do these things. But we should not single out home birth, with only a handful of preventable deaths per year, when there are so many other preventable childhood deaths and thus so many other ways for parents to act to save the lives of their children.

The Value of Home Birth

To this point, I have argued that given our other societal views about risk, safety, parental autonomy, and parental responsibility, opposition solely to home birth is not rational. Home birth is no more risky than many other ordinary behaviors that we currently allow parents to choose either for their children or for themselves, where this choice endangers the life or health of their child. I said previously that the trade-off home birth families make are "very similar" to the trade-offs many of us make every day. But I do not think the trade-off is precisely the same. And the differences between the two kinds of examples may make the choice for home birth even more rational than this first argument would allow.

Individuals who give birth at home, often do so because they believe that giving birth can be a deeply moving and empowering experience for their families[23]. And so in this way, giving birth is very different from the example of driving or having a swimming pool that we considered above. For some, the choice to give birth at home is not simply a choice to promote freedom or avoid the harms of hospital birth: it is the choice to promote the empowerment of birthing mothers. Giving birth can be empowering when individuals who do so are agents of a challenging, painful, and uncertain process and can accomplish the outcome (the birth) in an authentic way.

So the goods secured by a non-medical, non-hospital based childbirth are not simply the goods of freedom and efficiency, or the avoidance of harms that often occur in hospitals. They are also goods that are potentially more personal, powerful, and centrally important to those who give birth at home and potentially valuable to many more individuals as well.

[23] Birthing From Within by Pam England and Rob Horowitz, Partera Press, Albuquerque, NM, 1998. Brought to Bed, Judith Walzer Leavitt, Oxford University Press, New York, 1986. The Business of Being Born, film…

In what follows, I argue that home birth is typically empowering to those giving birth, while hospital births are typically disempowering. Because of this, I believe society should encourage home births for those who are interested in them and at low risk for complications during labor.

Why is home birth empowering and hospital birth disempowering? To answer this question, I will paint a picture of home birth and of hospital birth, focusing on certain salient aspects of each. Necessarily these pictures will be incomplete. And there are no doubt empowering hospital births and disempowering home births. But on the whole, there are a number of important features in home births and other features in hospital births that contribute significantly to the empowering nature of the former and the disempowering nature of the latter.

When people give birth at home, they labor and give birth in the setting in which they feel most comfortable, confident, and at ease.[24] They have, as we say, "all the comforts of home," around them and have people with them with whom they are comfortable. Giving birth for the first time is an experience unlike any other. Some individuals are more calm and comfortable doing so in their own home. Furthermore, because home birth care is largely one-on-one (one midwife for every laboring mother, where the midwife typically stays for the entire labor and birth) the care may be more attentive to the laboring mother than in the hospital,

---

[24] American College of Nurse Midwives, Statement on Home Birth. http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000251/Home-Birth-August-2011.pdf
"Midwifery Provision of Home Birth Services," American College of Nurse Midwives, July 2016: http://onlinelibrary.wiley.com/doi/10.1111/jmwh.12431/full

where the labor and delivery nurse may have more than one patient at a time, may rotate on or off in the middle of a labor, both of which may decrease the focus on each patient.[25]

In hospital birth, people in labor may be less comfortable, simply in virtue of the fact that they are not at home. Moreover, birthing mothers must, of necessity, change locations while in labor (from home to hospital). They are also subject to a set of rules, regulations, and practices that are designed for all people in labor, perhaps designed most of all for people at high risk for complications. As a result, in the hospital, whether a particular rule or practice is good for a particular person, still that person is subject to that rule or practice. For instance, hospitals often require the insertion of IVs for all people in labor. This is typically to provide hydration and also to have an IV in place in case of a rare emergency complication. Also because of the concern about emergency complications, people in labor are typically not allowed to eat or drink, even if their labors are very long and they become hungry or thirsty. But this can increase the discomfort of labor if the individual in labor feels hungry or thirsty. Moreover, having an IV makes moving around much more difficult;[26] it also changes the patient's self-concept, making it more likely that the patients see themselves as sick. All of these changes (being deprived of food and drink, having obstacles to moving around, and seeing oneself as sick) make it less likely that people in labor will be calm and confident agents

---

[25] Midwives in the home birth setting typically provide "continuous labor support," in contrast to labor and delivery nurses in the hospital. Jeanne Green, et al, "Care Practice #3: Continuous Labor Support," The Journal of Perinatal Education, Summer 2007, 16(3): 25-28. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1948096/

[26] Most women report some laboring in bed for significant portions of their labor and having an IV. "Major Survey Findings of Listening to Mothers III: Pregnancy and Birth," The Journal of Perinatal Education, 2014 Winter, 23(1): 9-16. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3894594/

of their birth experiences. These are just two examples (requiring an IV and forbidding eating and drinking) of ways in which hospital birth can disempower those who give birth there.

The lessons we can draw from these two pictures are as follows: hospital birth typically sees the laboring person as essentially passive, someone to be acted upon by others (doctors, nurses, technicians, etc.). While for some people, being acted upon can be a source of reassurance ("someone else is taking care of this, so I don't have to,") for others it can be a source of frustration, alienation from the process of labor, alienation from the laboring person's own body, and even alienation from the outcome of labor, the baby. On the other hand, the home birth typically sees the person in labor, not as a passive patient, but as an agent. To be sure, this is an agent who will, in some sense, be passive during a portion of the labor. But even while waiting, the laboring mother will be encouraged, in a home birth, to do various things: walk, eat or drink, shower, be in a hot tub. The attendants of labor (the midwife, the partner, possibly a doula – a layperson who supports the person in labor) also recognize the passivity inherent in parts of labor and institutionalize their response to this waiting by providing continuous labor support. Hospitals, though they employ "labor and delivery nurses" typically cannot provide continuous labor support: the workload of labor and delivery nurses does not typically allow this. In the hospital, the laboring mother will often find herself in bed, attached to an IV and/or an electronic fetal monitor. These practices make moving around quite difficult, which in turn makes pain management more challenging and contributes to a feeling of passivity. As a result, in the hospital, it is not just that the process of labor is partly a passive process, but rather it is that the laboring mother is explicitly and implicitly encouraged to be passive. Hospitals, as institutions are not currently designed with actively laboring and giving

birth in mind. Rather they are designed with a sick person, largely in bed, primarily in mind. And this model does not, for several reasons (the laboring mother is not sick, it is typically best for people in labor to move around rather than stay in bed) fit the laboring mother very well.

On the other hand, in the home birth setting, the laboring mother is at the center; moving around is encouraged, as is trusting that the body knows how to give birth. In the hospital, the doctor is at the center, and the idea is that the expertise of the physician is what ensures the safe birth. Even the language used to describe the act of giving birth varies, and significantly so: at home a midwife is said to "catch" a baby, an essentially passive act, and one that honors the laboring mother as the actor. In the hospital, the doctor is said to "deliver" the baby, suggesting that the doctor is the actor effecting the separation of these two individuals.

It should not be forgotten that the word 'patient' is derived from the Greek word, *pathos*, which means 'to suffer.' A patient is one who suffers something (suffering an injustice, suffering from an illness, being a long-suffering person), and as such, the patient is acted upon by another event (an illness) or by an agent (someone who does them an injustice). Moreover, suffering is an undesirable situation to be in. But suffering is not the best set of norms for understanding the person in labor. Being in labor, while undeniably painful for many people in labor, need not be seen as an experience of suffering, neither in the sense of being passive nor in the sense of it being undesirable.

I would draw three lessons from these contrasts between home and hospital births. First, many people in labor find giving birth to be a profound and moving experience. Some describe it in almost religious terms, as a sacred experience. While it is not impossible for a hospital birth to be profound, moving, or sacred, the institutional setting, the necessity of many

people coming and going, and the treatment of the person in labor as essentially passive, makes it very challenging to experience birth as profound, much less, sacred. Second, the home birth, because it sees the laboring mother as at the center, and structures supports (for instance, continuous labor support, having a variety of active comfort measures including a shower, hot tub, moving around, etc.) based on this particular individual's needs, encourages people in labor to see themselves as agents within a partly passive process. And when people see themselves as agents in processes that are uncertain, challenging, painful, and scary, they can feel an enormous sense of confidence, accomplishment, and strength precisely because they were agents of this process. Finally, hospitals aim to remove as much uncertainty from the process of giving birth as possible. To some extent, of course, this is important and contributes to safer outcomes for childbirth today. In 1900, for instance, up to 9 out of every 1000 births resulted in a maternal mortality.[27] Someone who gave birth five times would have a nearly 5% chance of dying in childbirth. Giving birth 10 times, the chance of dying in childbirth would be almost 10%. But even as we acknowledge this important truth, we should also acknowledge that while it might be possible to remove all or most of one kind of uncertainty from the process of giving birth (the cesarean section rate is about 82% in Brazilian private hospitals,[28] is about 68% in Shanghai China,[29] and in one hospital in California in 2016, the rate was nearly 70%),[30] doing this may not be desirable, and for at least two reasons. First, medically, the outcomes are not as good as when the cesarean section rate is between 15 and 20%. But

[27] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm
[28] https://www.theatlantic.com/health/archive/2014/04/why-most-brazilian-women-get-c-sections/360589/
[29] https://www.nytimes.com/2017/01/09/health/c-section-births-china.html
[30] See for instance, https://opinionator.blogs.nytimes.com/2016/01/19/arsdarian-cutting-the-number-of-c-section-births/

second, as a philosophical matter, there is value in learning to cope with uncertainty. As Iris Murdoch so nicely puts it, "the world is aimless, chancy, and huge… [and g]oodness is connected with the acceptance of real death and real chance and real transience."[31] Life is risky and we lose the ability to cope with this when we attempt to purify all our experiences of risk. Doing so produces worse outcomes medically, but it also habituates people to be less able to embrace and respond to the inherent riskiness of life itself. Home birth, on the other hand, for the low risk person, provides an opportunity to be an agent of a partially passive, inherently risky process whose outcome is neither certain nor guaranteed. And as one woman put it, in reflecting on giving birth to her child at home, "If I can do that, I can do anything."[32] Not all people desire to give birth at home. But for those who do, this can be one of the most empowering experiences of their lives.

Before closing, I consider two important objections to this view. First, one might object that defending the value of home birth considers the experience of white birthing mothers as central, while overlooking the experiences of black and brown birthing mothers. Black and brown people face significantly different problems in childbirth and parenting than do white people. Focusing on home birth continues to foreground the experiences of white people over those of black and brown people. Second, it might be objected that this essay focuses on the good of the birthing mother to the exclusion of the good of the fetus or baby. Indeed, the debate about the moral acceptability of giving birth at home seems precisely to pit the well being of the baby against that of the laboring mother. Someone who chooses to give birth at home, appears to value a certain kind of experience in childbirth – even an important

---

[31] Iris Murdoch, "SG", pp. 100 and 103.
[32] The Business of Being Born…

empowering experience – over the life of the baby. And when put that way, even if home birth is the most empowering experience a person can have, still it may seem vain and self-centered to value that over the life of one's baby.

In response to the first objection, we can emphasize that black and brown people, as well as white people, can benefit from giving birth at home. Indeed, some might argue that black and brown people can shield themselves from some of the institutional racism they might experience in a hospital by giving birth at home with a supportive midwife. The 2006 survey, "Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbirth Experiences,"[33] found that out of 1573 mothers interviewed, black, non-Hispanic mothers were least likely to have met their birth attendant prior to being in labor. It might be reasonable to infer from this that having a birth experience in which these mothers had a strong relationship with their birth attendant might make those birth experiences even more empowering. And even beyond transforming childbirth practices to make giving birth a better experience for black and brown mothers, it is equally important to attend to the harmful, oppressive experiences faced by black and brown mothers outside of the context of childbirth.[34] They are subject to intrusions into their parenting by the State at rates far higher than that experienced by white mothers. So even while we focus on home birth, society and its members must work to overcome this significant injustice.

Second, regarding the concern that my view considers only the good of the parent(s) and not the good of the baby, I respond that in general, babies do well when their parents do well. So allowing parents to give birth in the location of their choosing, where they feel safest

[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174380/
[34] Cite "Responsibility and Reparations for White Supremacy."

and most supported, will best enable them to best care for their infant after birth. Furthermore, as a matter of consistency, as a society, we allow parents (especially white parents) a high degree of parental autonomy in deciding various matters concerning the health and well being of their children. This is true for the decision to vaccinate or not, the decision to allow a child to play football or not, the decision to have a home swimming pool or not, and so on. And while it is true that we do not allow black and brown families this same parental autonomy, this is an injustice and something we must rectify.

Moreover, as we have discussed, we allow parents the freedom to decline to donate organs or give blood even if this is the only way to save the life of their child. And if we allow parents that amount of personal autonomy, we ought to allow parents the freedom to give birth in the location of their choosing.

Conclusion

Ultimately, my argument here is two-fold: first, I argue that in society we allow parents the parental autonomy to make decisions about competing goods for their child. Parents have the freedom to balance the competing goods of safety, efficiency, pleasant experiences, and so on. So even if a choice is somewhat less safe (driving 65 miles per hour, rather than 55; having a home swimming pool, rather than not; allowing a child to play football, rather than chess), we currently give parents the freedom to make that somewhat-less-safe-choice. In the same way, we should allow parents at low risk for complications in childbirth to have the freedom to give birth in the location of their choosing. Though I have not considered this issue at length, there are also good arguments for allowing home birth based on individual autonomy. As we have

seen, society permits parents to decline to donate their organs and their blood to their children in order to save the children's lives; in the same way, individual autonomy should protect a parent's freedom to choose the location for childbirth, even if this choice endangers their child to a small degree.

Second, I have argued that there are important goods that are promoted by home birth that either cannot be promoted by hospital birth, or have not been promoted by hospital birth. We should work to enable hospital birth to promote these goods; but at the same time, it is reasonable to allow people who give birth the freedom to decide where it is best for them to do so. Moreover, society and its members should work to make home birth as safe as possible, by developing clearer credentialing for home birth midwives, developing transfer protocols, and ensuring strong collaborative relationships between obstetricians and home birth midwives.