THE VALUE OF GIVING BIRTH AT HOME: PROMOTING SOCIAL JUSTICE THROUGH HOME BIRTH

ABSTRACT

Each year, a small, but committed, number of people plan a home birth and give birth at home. But given the best data currently available, it appears that in the US, home birth subjects the newborn to a twice-higher rate of mortality, as compared to hospital birth. As a result of this data, critics of home birth have argued that all births should take place in hospitals. They argue that it is unprofessional for physicians and midwives to be involved with home birth and irresponsible for parents to choose it for their births. Granting the validity of the data, I argue that home birth is no more dangerous than many ordinary activities society currently allows some parents to choose for themselves or for their children. I consider examples of activities like driving, swimming, and playing football. I also argue that home birth can empower people giving birth, in a way that hospital birth typically does not empower them. Empowerment and a safe space for giving birth may be especially important for marginalized groups who are giving birth. Home birth is, thus, a rational choice for low-risk people who desire an out-of-hospital birth.

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 seems likely to continue for some time, as public discourse continues to be sharply divided on

the issue. But lately, reproductive ethics have 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] questions about the high rate of maternal and infant mortality in the US, especially for black and brown pregnant people,[3] and concerns about the moral permissibility of giving birth at home. Each of these issues highlights harms that undermine the autonomy and damage the well being of people, especially during their reproductive and parenting years, which, for many, is a time of increased vulnerability. Adequate attention to reproductive ethics demands solutions to all these pressing problems. Here, I begin with the issue of home birth, though I also aim to show that the availability of home birth can add to our toolkit as we work to end racial injustices in pregnancy care, in pregnancy outcomes, and in parenting.[4]

BACKGROUND ON HOME BIRTH

A small, but committed number of people give birth at home in the United States and abroad[5] 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 – the remaining 25% are births that were planned to occur in hospitals or birth centers, but due to the unexpected onset and rapidity of labor, occur at home. According to the Centers for Disease Control and Prevention, it appears that the percentage of people giving birth at home has increased three-fold between 2004 and 2012 (from .56% of all births in 2004 to .72% of all births in 2009 and 1.4% of all births in 2012). In 2012 alone, 50,000 people in the US planned to, and did, give birth at home.

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 mortality[6] for those giving birth;[7] 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 home births 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, in order to optimize outcomes for pregnant people and babies, the ideal cesarean section rate appears to be 19%. This analysis finds that when the rate of cesarean births rises above 20%, morbidity and mortality for both those giving birth and their neonates increases.[8] The US Department of Health and Human Services has set a cesarean section birth target of 23.9% by 2020.[9] 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 person giving birth and the baby. So it is likely that more than 25% of births need to take place in hospitals.

Some people giving birth no doubt also feel most comfortable giving birth in the hospital. For at least some of these individuals, it may be best for them to do so. At the same time, however, many people already desire an out-of-hospital birth (either at home or in a freestanding birth center[10]) and others might desire this if given more information about birthing options. For the sake of these individuals, it is important, and timely for society to have a better understanding of the ethics of homebirth.

Much of the medical and philosophical literatures on home birth have focused on the safety of giving birth outside of a hospital.[11] 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 attitudes toward risk and on views of the goods that can be secured through giving birth in different locations.[12] 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 rather than in the hospital.

Home Birth Outcomes

Regarding the empirical matter of home birth outcomes, unfortunately, excellent data on home birth 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 might be difficult to persuade large numbers of people giving birth 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 we have on home birth outcomes currently suggest that people who give birth in hospitals receive more medical interventions during labor (including epidurals, electronic fetal 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. [13] 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.

The ethics of home birth, like some questions in reproductive ethics, appears to pit the well being of the parent 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.[14] Some members of the public may hold this view as well. Some arguments are also directed at birthing parents: 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 matter where one gives birth; all that matters is the outcome: a healthy parent 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 occasionally arise without any warning and in these rare 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.

Three Arguments for Home Birth

Even if there is some inherent risk to giving birth at home, I shall advance three 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. More precisely, in other spheres of parenting, we grant some (especially privileged) 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.[15] 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. 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 empowerment and well being. Especially because these goods accrue to parents some of whom are women-identified people, it is important to honor a family's choice to have a home birth and even expand the number of families who may choose it, when it is within certain guidelines.

Third and finally, home birth may also be an important aspect of social justice work. Because home birth often empowers people giving birth, home birth can promote social justice for women-identified people and for trans parents by promoting their empowerment. But home birth can also promote social justice by promoting racial justice. Allow me to explain. In the United States, childbirth outcomes differ drastically by race. Among the wealthiest 35 nations on the planet, the United States now ranks 32nd in its rates of infant mortality. But black infants fare much worse than their white counterparts: black babies have a rate of mortality of 11.3 per 1000 babies, more than twice the rate for white infants, whose mortality rate is 4.9 per 1000 babies.[16] The statistics for birthing parents are also grim: roughly 700-900 maternal deaths occur in the US each year, but black birthing parents are three to four times more likely to die from pregnancy related causes than are their white counterparts.[17]

The racial disparities between black and white pregnant people continue into parenting: I said above that society grants *some* parents the freedom of bodily autonomy. I say this because society currently distributes this freedom unevenly: white parents have far higher degrees of parental freedom and parental autonomy (including the freedom to make parental mistakes) than do black and brown parents. For black and brown parents, an understandable transgression (leaving school-age children in a nearby parked car during a job interview) often leads to criminal charges for the parent and the placement of the children in foster care. For white parents, even major transgressions, such as leaving a 2-month old infant on the roof of one's car

and driving off under the influence of drugs, seem to be treated mildly by the criminal justice system (in this case, with probation only and no removal of the child).[18]

The causes of these racial disparities are complex and not fully understood. However, institutional racism, both in society generally and in institutions such as hospitals have a persistent and terrible effect on black and brown birthing parents and their babies. One theory that is gaining prominence is the idea that persistent institutional racism is an important cause of low birth-weight in infants, pre-term labor, pre-eclampsia, and high blood pressure for black and brown birthing parents. More evidence is needed to substantiate this theory; but as researchers accumulate that evidence, it makes sense that the work of anti-racism and social justice can, in part, involve creating an anti-racist space for giving birth. My third argument is thus that home birth, attended by midwives who are anti-racist, can be one such space.

Still, some might argue that my view seems to *perpetuate* an injustice because much of my argument takes the white parent's perspective, in parental autonomy, in the desire for home birth (at present many home birth clients are white) as normative. I agree that there are ways in which taking a white parent's view as normative for everyone is unjust. But here, I take the white parent's perspective as normative only in the sense that all parents ought to have this same parental freedom. It is sadly true that black and brown parents currently lack the freedoms that white parents have: the US is a racial democracy and this redounds to our treatment of all citizens, including parents.[19] But this is a truth that society should work hard to eradicate. My third argument is thus that home birth can make a small contribution to that social justice work.

Before turning to the matter of home birth safety, I have one final caveat: one might think that this debate rests largely on convenience. On some views, what is important in a home birth 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. Rather my focus is primarily on the cultural norms that abide in hospitals versus those that abide in out-of-hospital births. I argue that the latter empower people giving birth, the former do not. But first we examine the argument that society should not allow home birth (should make it illegal, sanction practitioners who participate in it, and so on) because it is less safe than hospital birth.

SAFETY FIRST?

We have seen that being born at a planned home birth appears to subject babies to a twice-greater risk 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 argument is correct, we must 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).[20]

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.[21]

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.[22] This means that nearly 1000 children are killed every year in US 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.[23]

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.[24] 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 also better trauma care to improve the survivability of car crashes.[25]

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."[26]

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.

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 more 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 could be 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. And while it is true that society has begun to question the safety of football, it is also true that many families still sign their children up to play football every fall. A quick trip to one's town sports field will confirm the presence of helmeted and padded children age 10 and up playing and practicing tackle football each week between August and December.

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 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 giving birth. For a black or brown person, this might also include the freedom to be free(r) of racism during the birth process. Thus in its promotion of freedom, giving birth at home is in this way much like driving: both promote freedom at the cost of some small number of 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 2014, rates of cesarean birth remained at about 32.2% of all births,[27] 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 32% 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.

Black and brown pregnant people face myriad harms in pregnancy, childbirth and parenting. In addition to unacceptably high rates of infant and maternal mortality, black and brown pregnant people experience institutional racism in their interactions with medical providers.[28] Home birth may thus also be important because it offers a way to give birth outside of the institutional context, with more insulation from institutional racism than one might find in a hospital.

At the same time, it is important to acknowledge that some black and brown pregnant people may have difficulty accessing out-of-hospital births and midwifery care due to insurance barriers and the social "misconception that natural and home births and doula and midwifery care are luxury concerns of white middle-class women."[29] Julia Chinyere Oparah argues that while the alternative birth movement (a movement predominantly by and for white women, defending natural birth and midwifery care) has been plagued by racism and an implicit commitment to white supremacy and white solipsism (the view that white people are at the center), still the aims of that movement – to promote birthing justice, midwifery care, natural and home birth – are in line with the aims of women of color "to challenge medical violence and coercion during pregnancy and childbirth, to reclaim midwifery traditions in communities of color, and to raise awareness among women of color about strategies to overcome birth inequities."[30] Birthing justice that is sensitive to the history of racism and white supremacy requires advocacy of midwifery and home birth, but also requires that pregnant people can choose midwifery and home birth regardless of ability to pay.[31] Chinyere Oparah argues that, "the struggle for access to

birthing alternatives is inseparable from struggles for racial, economic, and social justice and the fundamental transformation of global maternal-care systems."[32]

Some black and brown pregnant people desire natural childbirth, in a non-hospital setting, attended by a midwife.[33] Some might choose home birth to avoid being subject to institutional racism in a hospital. Others might choose home birth in order to have a close relationship with their midwife: black and brown mothers are far less likely than their white counterparts to know their birth attendant during a hospital birth: the 2006 survey, "Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbirth Experiences,"[34] 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. But even if the birthing mother in a hospital has a close relationship with her own childbirth provider, the birthing mother will nevertheless encounter many more people in the hospital (nurses, phlebotomists, anesthesiologists and other specialists) and is likely to experience racism during the labor process. A home birth, by contrast, has many fewer people in attendance, offers the close relationship between birthing mother and midwife, and thus the birthing mother may be less likely to experience racism during the birth. For all these reasons, I argue that home birth, when paid for by all insurance including Medicaid, represents an important aspect of social justice and racial justice.

In addition to being a potential aspect of racial justice in childbirth, home birth can be an important option for all people giving birth who are at low risk of complications. And it can be rational to choose home birth, even with its potentially higher risk of adverse event. In other contexts, 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. The person who gives birth at home, accepts a very small risk of a terrible event (the death of their newborn) in exchange for the far greater chance of having an empowering, beautiful, anti-racist and intervention-free birth, that also promotes parent-infant bonding, breastfeeding, and life-long, healthy gut-bacteria for the newborn. It is no doubt difficult to quantify these benefits, as it is also difficult to quantify the benefits of getting to work a little quicker, but in many realms of life, we regard it as rational to make this trade-off. Rationality thus requires allowing families to make this trade-off in giving birth.

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 (or all people) 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 under any circumstances. Rather, it suggests that we should strive to make home birth safer. The reticence of some to do this seems to suggest that opposition to home birth outstrips concerns about its safety. 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 rectify this, 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. Given that 50,000 or more families give birth at home each year, the home birth opponent should be open to institutional changes that would enable people to more safely give birth at home. Without this openness to institutional change, it can seem that home birth opponents are not just instrumentally opposed to home birth: that is, opposed because of the current state of safety. Rather, one suspects that some people might be opposed to home birth in all possible iterations and arrangements of it. I will return to this argument in the section on promoting empowerment through home birth.

I also believe that we should strive to make hospital birth safer by reducing the maternal and infant mortality rates, especially for black and brown families, and we should strive to make hospital birth more appealing, by reducing the number of interventions, by allowing birthing mothers the same freedoms enjoyed by people who give 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 (make home birth illegal and prosecute midwives who attend births at home or even prosecute families who intentionally give birth at home, for instance), we must also legally require parents to drive more slowly (55 MPH for parents?), make it illegal to have backyard swimming pools, and make it illegal for children to play football, ride bikes, etc. 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 – either legally or morally – 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 (privileged) 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.[35] 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 support 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 who might choose to give birth at home.

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.[36] 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 person in labor, where the midwife typically stays for the entire labor and birth) the care may be more attentive to the person in labor than in the hospital, 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 can decrease the focus on each patient.[37]

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;[38] it also changes the patient's self-concept, making it more likely that the patients see themselves as sick or at risk. 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 of their birth experiences. These are just two small examples (requiring an IV and forbidding eating and drinking) of ways in which hospital birth can disempower those who give birth there. Moreover, we saw earlier that black and brown mothers experience institutional racism and disproportionately bad outcomes: they face high and unjust rates of infant and maternal mortality in the US.

The lessons we can draw from the pictures of hospital birth and home birth 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. In addition to these "routine harms" faced by all laboring people, black and brown people in labor face persistent, pernicious institutional racism. Home birth can provide an anti-racist space for

birth, and anti-racist midwives can provide excellent prenatal care, perhaps providing a small antidote to ever present institutional racism.

For a variety of reasons, in different ways, home birth can empower all people giving birth: in a home birth, the person in labor is not a passive patient, but an agent. But even while labor requires waiting, the laboring mother will still 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 person will often be 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 person 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 primarily with a sick person, largely in bed, in mind. And this model does not, for several reasons (the person in labor is not sick, it is typically best for people in labor to move around rather than stay in bed) fit the person in labor very well.

On the other hand, in the home birth setting, the laboring person 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 is acted upon by another event (an illness) or by an agent (someone who does them an injustice) and also one who suffers something (suffering an injustice, suffering from an illness, being a long-suffering person) in the more everyday sense of that term. Many of us regard suffering as 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 four 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, in the sick role, and at risk, makes it very challenging to experience birth as profound, much less, sacred.

Second, the home birth, because it sees the laboring person 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.

Third, 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.[39] 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,[40] is about 68% in Shanghai China,[41] and in one hospital in California in 2016, the rate was nearly 70%),[42] doing this may not be desirable, and for at least two reasons. First, medically, when hospitals have a high rate of cesarean birth, the outcomes are not as good as when the cesarean section rate is between 15 and 20%. But 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."[43] Murdoch's point should not be taken to license recklessness. But rather she acknowledges the truth that life is risky and we lose the ability to cope with this when we attempt to purify all our experiences of risk. Attempting to purify birth of uncertainty by using the cesarean birth in most births, produces worse outcomes medically, but 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-identified person put it, in

reflecting on giving birth to her child at home, "If I can do that, I can do anything."[44] 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.

Fourth and finally, for black and brown laboring people, home birth has the potential to offer a space for giving birth that is more inoculated against institutional racism than is the hospital. Black and brown laboring people can choose midwives and doulas who are anti-racist. And because the institutional overhead is small for home births, unlike hospitals, there is a greater likelihood that all those involved in a birth will contribute to an anti-racist birth experience.

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 people as central, while marginalizing the experiences of black and brown birthing people. 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 parent 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 parent in labor. Someone who chooses to give birth at home, appears to value a certain kind of experience in childbirth – even an important 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 experience 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, I have argued 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. Because black and brown people are less likely to know their birth attendant when they give birth in the hospital, it is reasonable to suppose that having a birth experience in which these parents had a strong relationship with their birth attendant might make those birth experiences empowering rather than disempowering, as they often are in the hospital. And even beyond transforming childbirth practices to make giving birth a better experience for black and brown parents, it is equally important to attend to the harmful, oppressive experiences faced by black and brown parents inside and outside of the context of childbirth.[45] As we have seen, they are subject to intrusions into their parenting by the State at rates far higher than that experienced by white parents. So while we focus on home birth, society and its members must also 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 it is likely that babies do well when their parents do well. So allowing parents to give birth in the location of their choosing, where they feel safest and most supported, will best enable them to best care for their infant after birth. Furthermore, even if there is an inescapable tension between the good of the birthing mother and the good of the infant, 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 some 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 birthing families the freedom to decide where it is best for them to give birth. 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. Doing all this empowers people who give birth, and may especially be of benefit to black and brown parents who must otherwise continue to cope with institutional racism while giving birth. Home birth can help all parents begin or continue their journey as parents with the foundation of an empowering birth.

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