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Commentary

Community Versus Out-of-Hospital Birth: What's in a Name?

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The term *out-of-hospital* has long been used as a kind of shorthand to refer collectively to births that occur in birth centers or at home. However, this term has also been a persistent cause of concern among health care providers who attend births in these settings, and researchers and midwives are increasingly adopting the term *community birth* instead to refer to planned home and birth center births.[1–3] Some who resist the term *out-of-hospital* have argued that it reifies hospital birth as normative and community birth as other, marginal, or alternative. Here we propose *community birth* as a preferable term because it labels the practice for what it is—instead of for what it is not.

This argument is similar to those made by communities of color who have critiqued the use of *nonwhite* as a demographic category that elevates Euro-Americans as the default race.[4] Medical anthropologists have also compared the use of the term *out-of-hospital* to the tendency to call nonallopathic forms of healing *complementary* or *alternative*.[5] Yet, many so-called complementary and alternative medicine practitioners prefer to identify their forms of healing as holistic, integrative, or functional to indicate that modalities such as acupuncture, Ayurveda, chiropractic, and so on are autonomous approaches that may exist outside of, but are not subservient to or less than, allopathic and biomedical modalities. These health care providers, too, commonly choose to refer to their practice with terms that convey what it is, rather than what it is not, just as persons of color choose to be identified for who they are, not for who they are not.

We recognize that *out-of-hospital* is commonly used simply out of convenience and not in an overt attempt to other or rank birth settings. It may seem easier to say "out-of-hospital" than "home and birth center births." To date, there exists little evidence of significant differences in outcomes between planned home and planned birth center births in high-resource countries.[6,7] Hence, we agree that a concise and convenient umbrella term for home and birth center locations is needed, as it will facilitate pooling of data across these service locations and increase power for studying rare outcomes. We object, however, to that term being *out-of-hospital*.

Furthermore, by framing births that occur in community settings as not hospital births, one is tacitly conveying that hospital births are the gold standard. With soaring costs[8] and overuse of potentially harmful interventions including continuous electronic fetal monitoring[9,10] and cesarean birth,[11–13] we do not believe that hospital birth practices are the ultimate standard toward which all individuals, communities, and nations should strive. Although hospital births are certainly more common in high-resource nations, community settings can offer high-quality, affordable, culturally aligned care and comparable outcomes for healthy women with uncomplicated pregnancies.[14–16] In addition, the demand for community births is growing in many regions of the world[17–19] as data on the harms of overintervention, which is more common in facility births,[16,20] receive increased popular and scholarly attention.[21–24] High costs of care,[8,25] poor postpartum follow-up,[26,27] and a concentration of disrespect and abuse in hospital births[28] also influence decision making around birth setting.[29–33] Thus, attempts to uphold facility birth for all as the global norm will likely continue to be met with resistance, even if this standard were feasible economically and logistically. We believe it is important to develop an equitable lexicon that facilitates examination of birth outcomes across a full range of settings, health care provider types, and strategies for reducing preventable maternal and newborn death and suffering.

Those who participate in community-to-hospital transfers frequently witness what can happen when such a respectful and inclusive lexicon is missing. It is common in hospital settings, for example, to describe women who have transferred from home to hospital during the intrapartum period as *failed home births*. This term can become so routine that it is used thoughtlessly in the presence of the laboring person and/or their partner.[34] Although we recognize that *failed home birth* is not a direct result of the use of term *out-of-hospital*, we do see the 2 terms as emerging from similar conceptual spaces wherein maternal autonomy in choice of birth setting is disrespected and women's bodies are assumed to be dysfunctional and in need of massive technological intervention to produce a healthy child. To that end, we might further recognize that the word *fail* can be damaging whenever it is used in clinical care, including terms such as *failed induction*, *failed vaginal birth after cesarean attempt*, and *failure to progress*.

In addition, the language of failure, and specifically the use of the term *failed home birth*, contributes to the misconception that transfers to specialized personnel or facilities are a type of adverse outcome or morbidity, when in fact they are an important indicator of effective primary care and appropriate triage. Health systems do not describe women who

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transfer from rural or smaller hospitals to referral or tertiary hospitals as *community hospital failures*, nor are referrals to maternal-fetal medicine specialists referred to as *primary care failures*. The development and utilization of regionalized maternal and perinatal care systems is considered essential to the provision of high-quality care, and the movement of patients across levels of care should not be shamed but instead accepted as a normal part of the care process for some patients. In fact, jurisdictions where community birth settings are well integrated into maternity care systems that facilitate access to specialized care—when it is needed—are associated with optimal maternal and newborn outcomes.[35–37] We posit that maternity care providers could improve the quality of care for all people if we work collectively to change our thinking and language to support positive, collegial, interprofessional communication that conveys respect for maternal autonomy and the innate capacity of women's bodies to give birth when they are healthy and appropriately supported.

So, what's in name? Does our language matter? We argue that it does. The recent trends in person-centered, respectful, and gender-inclusive language suggest that our words and labels matter quite a bit, perhaps particularly so to those who are experiencing the trauma that comes from being othered, excluded, or misidentified. It is worth noting that our Dutch colleagues often refer to hospital birth as *out-of-home birth*, highlighting the degree to which language and culture shape our perceptions of normality.[38] In the spirit of using our words to describe and unite rather to than to obscure, harm, or discredit, we call for the widespread adoption of *community birth* to refer to planned home and birth center births in the United States, as well as the cessation of the term *failed home birth* when referring to transfers.

CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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