Home births in New Zealand: Perspectives of a Fellow and a Midwife

In July 2004, Sarah Tout, a Fellow in Dunedin and Anne Whyte, a midwife in Auckland were invited to amicably discuss their expert views about home births in New Zealand by teleconference. The aim of this interview was to not only encourage both practitioners to comment about the practice issues and dilemmas of home births, but to also encourage free discussion about their work with their patients. Fellow and midwife were also able to ask each other questions and compare practice issues across New Zealand.

Anne Whyte is a midwife whose patients are primarily women in impoverished households in South Auckland. The majority of these women elect to deliver their babies in hospital or at a birthing centre, but occasionally Anne does agree to requests to deliver her patients at home.

Over ten years as an independent midwife, Anne believes she would have overseen between six and eight home births per year. The number of requests has now fallen to about 'four a year' for her, but a HealthPac audit of her organisation Southern Auckland Maternity Care Ltd (SAMCL) in 2002-2003 indicated that home births would have accounted for ten per cent of the 12,000 births overseen by SAMCL members. She estimates that 1.25 per cent of those home births would have resulted in women being transferred to hospital for minor bleeding, extra suturing or neonatal distress.

The Ministry of Health has put the national estimate for home births in New Zealand at between five and seven per cent, says Sarah Tout. However, the Ministry of Health has not to date included the official number of home births in its live birth statistics. Sarah believes that it is still too early to be able to draw on conclusive figures from the last two years because reporting of home births was not mandatory before 1 July 2002.

As the statistics are still not conclusive, so the demographics of some women opting for home births are also still anecdotal. Anne Whyte comments that 'for a long time here in Auckland, home births were considered a white, middle class phenomenon' and that the majority of women she supervised were 'Caucasian and Tongan or Samoan', but it seems that the choice now is not just limited to any one demographic. She adds that 'some colleagues of mine have occasionally assisted women from some small, select groups' and that Maori midwives arrange many of the home births for Maori women.

CONTINUITY OF CARE

Anne Whyte cites continuity of care as a key reason that some women are requesting home births. 'Continuity of care was raised in some of the studies about home births in the UK', says Anne. 'I think that women do prefer to be served by familiar faces in private surroundings, but that's not necessarily in their own homes, that could be in hospital as well.

'People also like to know and feel confident about the people who are looking after them. If we have to call a specialist [for an obstetric opinion], the woman feels a lot better because she actually knows the specialist that we work with and may have already met the specialist antenatally. On the other hand, if you have to use the closed unit at the hospital in an emergency, the woman may have to be treated by medical personnel that she has never met before and she just doesn't have that same level of trust in them. It's also no doubt difficult for the medical personnel as well because they have to win her trust and confidence.'

Sarah Tout agrees that continuity of care is a factor in a patient's choice of delivery. 'I've had similar feedback from my patients. Meeting lots of different people in a desperate situation is not pleasant for anyone.'

Although obstetricians and gynaecologists traditionally disapprove of home births as an alternative model of maternity care, Sarah Tout and Anne Whyte are in agreement that the disapproval is for the most part over the 'actual practices' employed in a home birth situation.

'My feeling about home births', explains Sarah Tout, 'is that they can never stand alone because they will always need hospital back-up when there are problems. I think one of the keys to home births is good screenings for the women to reflect a low risk population in the first place and to educate a woman so that she understands that even though she is low risk there can be unforeseen problems that arise. It's also important that she understands that transfer to hospital may be required.

The participants

Sarah Tout is an obstetrician and gynaecologist at Dunedin Hospital, which oversees 1700 deliveries per year. The hospital is a tertiary referral centre in association with the University of Otago and is also a training hospital in the College's Integrated Training Program.

Sarah began her Membership training in O&G in 1992 and spent her registrar training in New Zealand, the United Kingdom and Fiji. She gained her Fellowship in June 2001 and started work as a specialist in December 2001.

She works in full-time public practice in general gynaecology, obstetrics and colposcopy. Sarah Tout is also the Honorary Secretary of the New Zealand Committee of the RANZCOG.

Anne Whyte works for the SAMCL, which is part of a maternity provider network that comprises 300 lead maternity carers, including midwives, specialist obstetricians and general practitioner obstetricians in Auckland, Christchurch, the Coromandel, Gisborne, Hamilton, Rotorua, Tauranga, Wellington and Whakatane. She has 20 years of nursing experience, which includes nursing work in psychiatry and public health.

Anne graduated as a midwife in 1990 and worked in the public hospital system from 1990 to 1993. Since 1993, she has worked as an independent midwife in South Auckland, overseeing deliveries in homes, level one units and obstetric hospital units.

'Certainly the home births that I have been upset about have been ones that have been managed badly. I think that in a lot of units in New Zealand, things work well when there's close communication between midwives and obstetricians and midwives referring appropriately and obstetricians being available when there's a problem.'

Anne Whyte agrees that home births should not stand alone from hospital support, but believes that the risks for a woman who gives birth in a small, peripheral hospital are comparable to the risks for a woman who has a planned labour at home. 'To me, there are similarities between home births and deliveries in a small, peripheral hospital', she elaborates, 'especially when you consider that there is encouragement for women to actually deliver outside of a base hospital. The facilities in a peripheral unit are very similar to what we would employ at a home birth. There's no doubt that women preparing for a home birth should be as rigorously screened as women wanting to give birth in hospital and of course, you need to be very careful and you need to know what your back-up is like. You also need to be very confident in your midwifery practice and be very confident about referring if you need to. For me, the safe outcome for the mother and the baby is the primary consideration.'

SEPARATING ROMANCE FROM REALITY

To ensure a positive outcome for mother and child, Anne Whyte says that she is very particular with her patients about what she can and cannot do as a lead maternity carer in a home birth.

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'Some people have a very romantic idea about home births which is completely separate from the reality', she says. 'You really have to sort out the unrealistic expectations. Most importantly, you have to tell them what it is as a practitioner that you don't do. For instance, I don't practise water births. If that was what she wanted I would refer the woman to someone who does. I would recommend that a woman who is diagnosed with twins should go into hospital. If I think we need to transfer a woman to hospital, then we move quickly. We are not going to have a long discussion and argument about it. I believe in using technology and medical science when it's necessary. You have to be very clear about that to the women that you're looking after so that they realise they may have to be moved and that if they are transferred, it will be very uncomfortable.'

Sarah Tout's advice to a woman who is considering a birth outside of a base hospital echoes Anne's comments. 'I would go through her past medical history and past obstetric history, if she has one, to exclude any risk factors. One of the things that Anne has talked about is the similarity of a home birth and a birth in a peripheral unit that doesn't have obstetricians on site. Obviously I have had more dealings with these units than actual home births. For me there is a difference between birthing at home and a peripheral unit that is staffed 24 hours a day with GPs and midwives. These peripheral units are set up with emergency facilities. However I consider a birthing centre to have the same facilities as a home birth.

'My primary reason to talk to someone about a home birth would be to exclude risk factors and then refer them back to their lead maternity carer to discuss the plan for the home birth. Certainly the things that I go through with those ladies is that the facilities are different

and that should they require or wish to have an epidural in labour, then they would need to be transferred to hospital. If there were an emergency, they would be advised to have an urgent transfer into hospital and warned that an ambulance journey in such a situation may not be pleasant. Another advantage of giving birth in hospital is that that there are paediatricians on site if there is an unforeseen problem with the baby at delivery.'

'My feeling about home births is that they can never stand alone because they will always need hospital back-up when there are problems.' Sarah Tout

GRAPPLING WITH UNFORESEEN CIRCUMSTANCES

Sarah Tout states, however, that even if all the indicators are that a home birth will be low risk, there are so many other variables that can happen during the delivery, including 'shoulder dystocia, bleeding after delivery, an undiagnosed abnormality with the baby that would require skilled paediatric intervention and sudden fetal distress following separation of a placenta'.

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'I think you can minimise your risk by screening', Sarah adds, 'but there is always still an outside chance that there will be an unexpected complication.' She cites two examples that she has encountered in women who were rushed to hospital after attempting to have planned births at home.

'One case was an extremely well managed labour at home,' Sarah recalls. 'The mother was very well when she came into hospital and the baby was very well, but the baby was stuck and not coming through her pelvis. The baby's head was disproportionate to the mother's pelvis and she needed a caesarean section for that. But she had been looked after extremely well [by the midwives] and it was a safe, non-rushed glide into hospital and she and her baby were well. It probably wasn't the outcome the lady wanted, but she and the baby weren't put at risk and she was very happy with how things were managed.

'In the other case, the lady was low risk, but the labour had been very long at home, the membranes had been ruptured for a long time, she'd been fully dilated for a long time, and had pushed for a long time, and by the time she came into hospital, the baby was very ill. The woman required an emergency caesarean and although the baby was resuscitated, the oxygen in its blood was very, very low, suggesting that a problem had been going on for some time. The mother's caesarean section was very difficult because her uterus was exhausted, the tissues were very swollen and she had lost a lot of blood. As far as I know, the baby did recover, but if there are any abnormalities in the child, they may not show up until the first few months and years of life. So I felt that that wasn't managed well. The woman probably should have come into hospital a lot earlier and the outcome would have been a lot better if she had.'

Anne Whyte acknowledges that in that situation, it is critical to identify 'a problem like that and transfer long before that stage', but she also believes it is an example of how 'things can go wrong anywhere'.

'Sometimes, you may start worrying about potential problems like shoulder dystocia, you think "Oh, no, we're going to have to race to a base hospital because that's a big baby", but it's also the little babies that can catch you unawares as well. I also recently looked after a woman who had had a terrible experience at one of the peripheral units in a previous delivery', she recalls.

'She'd delivered and the baby had died within seconds of the birth. The woman was no risk factor, it was her first baby and everything appeared normal during the pregnancy. This time I booked her into Middlemore Hospital and referred her to an obstetrician antenatally. Eventually she requested a caesarean section because of the emotional state that she was in. But I think that underlines my point that home births, birthing places and peripheral units are all in a very similar category. We carry the necessary equipment, we train for contingencies and if there is a problem then that means we transfer our patients to a base hospital.'

Sarah Tout agrees with this point. 'In the current climate in New Zealand, all of these things can even happen in a tertiary unit behind closed doors. The key to avoiding it is being able to recognise when there is a problem and calling for help appropriately.'

ENCOURAGING UNITY AND TEAMWORK

Although they acknowledge that home births remain a sensitive issue amongst obstetricians and midwives, Sarah Tout and Anne Whyte believe that there is an instinctive desire, understanding and commitment by the two groups to work together and ensure that the best maternity services are available for women.

Anne Whyte is particularly full of praise for the midwives and obstetricians aligned with SAMCL who work very well as a team in emergency situations. 'We are very fortunate here because we have really good consultants that we can work with. I can ring any one of them and say that I am on my way and

they will go to action stations. I can also use the closed unit in an emergency, and find them very helpful when advised that we are on our way and why, and they will be standing by to help when you arrive. A lot of it is done on the hoof, so to speak, but once you become known in your area, the consultants take a lot more notice of your screaming and yelling! We had a very experienced midwife arrive in the back of an ambulance in the usual position with her patient who had a cord prolapse. It wasn't actually a planned home birth, the patient had wanted to deliver in hospital, but the midwife was just one-handed on the phone, telling them "We're coming to ED and have everybody standing by!"' And they were and the outcome was good.'

Sarah Tout is also optimistic that the Ministry of Health audit of the mandatory reporting of home births will enable obstetricians and midwives to work together more closely to improve the practicality of the alternative models of maternity care. 'I guess part of what I would hope to gain from the audit', she speculates, 'is that irrespective of whether the neonatal outcomes from home births in New Zealand reflect the figures in Australia and the UK or not, that we [the RANZCOG] can work through with the [New Zealand] College of Midwives what we can do together to improve safety in our practice.'

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Information kit on Down syndrome available to health professionals

Down syndrome is a chromosomal abnormality that occurs at conception. It is the most common genetic birth condition and occurs in approximately one in 700 births in Australia.

The Down Syndrome Association of Victoria (DSAV) is a not for profit organisation formed in 1978 to provide support and information to people with Down syndrome, their families, carers and health professionals.

The aims of the DSAV are to:

- provide understanding, support, information, and resources to people with Down syndrome and their families;
- share information and resources with service providers, health professionals, educationalists, students, government bodies and the community;
- stimulate community and professional interest in Down syndrome, for example, through speakers at forums and use of media;
- provide information, support, and resources to individuals who have been informed of a diagnosis during pregnancy;
- assist individuals with Down syndrome to achieve their full potential; and
- promote improvements in quality of life for people with Down syndrome.

The DSAV offers health professionals an information kit to use as an easily accessible and invaluable reference in the management and treatment of individuals with Down syndrome. Each kit includes:

- guidelines for medical practitioners,
- health check milestones,
- growth charts,
- brochures which address problems faced by parents, and
- other issues presented to parents and health professionals.

The information kit for health professionals may be obtained at a cost of $A15 from the DSAV. The DSAV encourages health professionals to put new parents in contact with the DSAV to ensure they receive appropriate support, encouragement, information and resources. The DSAV also provides parent information folders, free of charge to new parents that answer many of the questions asked by parents of a new baby with Down syndrome.

For further information about DSAV and Down Syndrome Awareness Week (from 10 to 17 October 2004), contact DSAV, 495 High Street, Northcote, Victoria 3070, tel + 61 3 9486 2377, fax +61 3 9486 2435, email dsavic@netspace.net.au, website www.dsav.asn.au