

# Home births in Australia: The midwife's perspective

*The claim that home birth is a viable alternative to hospital birth invariably causes controversy amongst Australian obstetricians and midwives. The complexities of the argument for and against the safety of home birth draw on the distinction between the medical understanding of risk and the home birth parents' understanding of risk. Minimising risk in medical terms results in more invasive, interventionist practice to counteract the fear of claims of negligence [Johanson and Newburn 2001, 2002] and higher insurance premiums to cover liability in practice, and it makes some women feel safe.*

Home birth women on the other hand, see birth as an intimate family event, rather than a medical procedure, and they value the privacy and control they have in their own home.

A study published in 2000, exploring the perceptions of risk amongst home birth parents found that parents considered three types of risk in their decision making: medical risks of pregnancy and birth, iatrogenic risks of medical practice and moral risks of going against medical authority (Viisainen 2000).

There are other dimensions to the home birth debate. Women's decisions are shaped by forces within society such as the media, health professionals and economics as well as the availability of services. In particular, options for care are affected by the way the medical understanding of risk is transformed into local policies and practices. In fact 'risk' is the core concept around which all perinatal services are designed and organised. It is interesting to note that the different interpretations within the same Western biomedical model of risk affect women differently in different countries. This suggests that there is something other than evidence of safety that drives government policies around home birth.

Women in the Netherlands for example, give birth at home unless they have an identified risk factor that compels

them to seek obstetric care in hospital. At least 30 per cent of all women give birth at home with a midwife. In New Zealand, legislation enacted in the 1990s established a legal right for midwives to offer home birth within the public health system. Since then the home birth rate has been rising steadily, including for Indigenous women. The UK and Scotland have always recognised the right for women to give birth at home, and the latest policy documents addressing the rising caesarean section rates and the need to reduce medical intervention, advise women to give birth at home wherever possible (NHS 2004). All of these countries have comparable rates of infant and maternal mortality.

*Women see home birth as an intimate family event, not a medical procedure...*

Australia, on the other hand, does not recognise home birth within the public health system. At present Australian midwives are unable to secure professional indemnity insurance. In some States and Territories, registration depends on professional indemnity and even where this is not the case many midwives have decided they cannot take the personal risk of practising uninsured. This situation limits availability and seriously impinges on a

woman's option to choose to give birth at home.

Neither systematic reviews nor randomised controlled trials are available to compare the relative safety and effectiveness of birth in hospitals with other alternative settings in Australia. The Cochrane database lists one randomised controlled trial comparing home to hospital birth. That study showed that women could be randomised to home birth, but included too few women to interpret the results (Olsen and Jewell 2001). Studies in the United Kingdom (Chamberlain et al 1999), the United States (Janssen 1994), the Netherlands (Wiegers et al 1996), Switzerland (Ackermann-Liebrich et al 1996), New Zealand (Gulbransen et al 1997) and Canada (Janssen et al 2003) have reported that a planned home birth attended by appropriately qualified caregivers appears to be as safe as a hospital birth. Currently we do not have evidence that hospital care offers clear safety benefits for low-risk childbearing families, and studies consistently find that it involves higher rates of intervention than other settings.

Implications for future research in the area of home birth must take into account the fact that the elimination of choice - as would be necessary in a randomised trial - could by itself have a

major impact on perinatal outcome by inducing insecurity and anxiety in women assigned to give birth in a manner that they do not prefer. In areas where the patient's choice has a profound effect on outcome, random comparisons eliminating choice will give unreliable estimates of true differences (McPherson, 1994).

A study of the planned home and hospital birth in the Netherlands found that 'for women with low risk pregnancies ... choosing to give birth at home is a safe choice with an outcome that is at least as good as that of planned hospital birth'. The authors concluded by saying 'there is self-selection among women who can decide for themselves where to have their baby, and that this preordains outcome, albeit to a limited extent. It is important, therefore, that the home birth option remains available, but especially that women at low risk are really given a free choice.' (Wiegers et al 1996)

**Assoc Prof Sally K Tracy**  
**AIHW National Perinatal**  
**Statistics Unit**  
**Sydney Children's Hospital**  
**Sydney NSW**

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## Reclaiming normal childbirth: 23rd Australian National Homebirth Conference, 30-31 October 2004

The 23rd Australian National Homebirth Conference, sponsored by the Birthplace Support Group Inc, Community Midwifery WA and Birthrites, will be hosted at Mandurah Gates Resort, Mandurah, WA, on 30 and 31 October 2004.

The conference is designed to mobilise participants, including doctors, midwives, childbirth educators and maternity consumers, to discuss and support strategies that encourage normal childbirth.

Key speakers at the conference include:

- Sarah Buckley, a New Zealand-trained GP obstetrician and mother of four children;
- Justine Caines, president of the Maternity Coalition, and secretary of Homebirth Australia; and
- Tracy Reibel, co-author of the National Maternity Action Plan.

The cost of attendance is \$A210 for the full conference or \$A120 for one day. The meeting has been approved for 12 RANZCOG CPD points.

For further information, visit the conference website at [www.edsite.com.au/birth/index.html](http://www.edsite.com.au/birth/index.html)

# Childbirth in our time: An obstetrician's perspective on home births

*Childbirth is an intensively emotive issue in all societies. It is surrounded by social, spiritual, cultural and familial implications. But in our society the dominant emotions are those of safety and the avoidance of pain. Thus the mode of maternity care which has most acceptance is that which, at least at first sight, offers the highest degree of safety, and access to the means of reducing pain, which is a hospital setting under the care of a doctor, quite possibly under three doctors, all specialists (obstetrician, anaesthetist and paediatrician). This model is intensively interventionist and the interventions 'cascade', resulting in a high rate of caesarean section.*

Childbirth is generously funded from public sources, but only on the presumption that the mother accedes to this paradigm. She has to fund any alternative herself, which gives the impression of satisfaction with the existing arrangements. There are choices of locality such as birth centres or different standards of hospital wards that may be more homelike, but home birth, and care from a lead professional other than medically qualified, is strongly discouraged.

A pregnant woman today is offered advice by a bewildering variety of health care professionals: doctors of various disciplines, midwives, maternity nurses (not necessarily equated with midwives), physiotherapists, childbirth educators, the list goes on. She is likely to receive conflicting advice from these persons, and becomes thoroughly confused. What is needed is a lead professional from whom she receives all advice, who interprets for her advice received from other sources. And it is ideal if this lead professional is the person who conducts the birth itself, that is, the midwife.<sup>1</sup> It is very difficult administratively for the midwife to have ultimate clinical responsibility in any institutional setting and midwife managed care is mainly equated with home birth.

Facilities for home birth compare well with those at small district hospitals where many births are conducted. Where there is not resident medical and theatre staff, emergency caesarean section after hours requires a time interval for these staff to arrive: the time taken for the patient to be transferred from home to hospital is not much greater. At such hospitals exceptional (maternal life threatening) situations are transferred to larger hospitals. Transfers from home can go straight to the larger hospital.

## *Home birth has advantages over institutional birth in several ways...*

There are not many scientifically acceptable studies of the performance of home birth against hospital births. In 1997 Chamberlain, Crowley and Wraight surveyed 5000 women in Britain who had home births in 1994 matched with 3500 controls. They concluded that 'the overall perinatal outcome ...[was] excellent', although there were some reservations due to the limitations of the survey.<sup>2</sup>

In 1997, a meta-analysis of 24,092 pregnancies from six studies concluded that perinatal mortality was not significantly different in home births from hospital births. Home birth (including cases transferred to hospital settings

for operative delivery) is associated with substantially reduced rates of intervention and lower caesarean section rates.<sup>3</sup> Both these surveys considered women having home birth by choice, not unplanned. The criterion was the intention to have the baby at home at the onset of labour.

Home birth has advantages over any institutional birth in a number of ways. First, the stress of getting to the birth location is eliminated. The concern as to how and when to move to the hospital or birth centre is a major stress just at a point where psychologically stress is particularly to be avoided. Regularly the press reports instances of a baby born on the way to hospital by the partner or a passerby or a taxi driver. Fortunately, this offers us a happy and amusing human interest story. How often tragedy results is not recorded, nor is there any record about the number of receding labours that occur once patients arrive at the hospital, a 'false alarm' that can be frustrating and demoralising for the patient.

Second, for many women the feeling of being in their own territory and comfort zone is very important. They feel stress free, in control and close to their families.<sup>2</sup> The value of such considerations are difficult or impossible to measure and are therefore given scant attention by scientifically based medical

advisers. The birth as a bonding event between the couple is also much enhanced and the closeness of previous children gives a valuable feeling of family involvement.

Third, for primigravid mothers, labour is better tolerated in the home. Myometrium is unstriated smooth muscle and has its property of being sensitive to psychosomatic influence: the state of the mind affects the performance of the body. Theories have been floated regarding the influence of endorphins in enhancing comfort and reducing pain. Grantley Dick Read in the 1930s promoted his theory of fear generating tension resulting in pain. Women vary as to what setting for

childbirth they regard as the most secure; many think of the hospital but a substantial number think of the home. To a large extent this is a matter of custom. In previous times hospitals have been regarded as alarming places; today hospitals are able to present a more relaxed image, whereas many women accept that childbirth at home is dangerous.

Much is made at this time of the right of the public to have input into their treatments and not blindly accept the advice of medical attendants; hence, the elaborate consent procedures that are now applicable before any surgery. The least that can be said about the safety record of home birth is that it does not justify the medical profession failing to

advise a pregnant woman of the option; she should be allowed to make her own decision. Medical funding systems should also recognise home birth under the care of a suitably qualified midwife as a genuine alternative to hospital care.

**Ralph Hickling FRANZCOG  
Applecross WA**

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## Lisa Metcalfe: A home birth experience

*If you are pregnant in our area, your care options are a private obstetrician, shared care with a GP and rostered hospital midwives, a midwives' clinic with a compulsory visit to the obstetric registrar at 36 weeks or a midwife in independent practice. There is no birth centre and the private hospital has a policy of bed births only.*

For my first baby I opted for shared care. My GP was experienced in obstetrics. Throughout the pregnancy I saw numerous midwives. At 35 weeks I saw yet another midwife who referred me to the obstetric registrar as presenting 'small for dates'. This fragmented level of care led to the pregnancy being

*'To me, a normal vaginal delivery is not about being tied to a drip and monitor while in labour...'*

induced. The result was an apparently 'normal vaginal delivery' of a healthy three kilogram baby boy. Normal vaginal delivery? To me, there is nothing normal about being attached to a drip and monitor while labouring or being given an episiotomy while pushing during the crowning of the baby.



*Lisa Metcalfe decided to have a home birth because she 'wanted continuity and a relationship with the person responsible for my antenatal care'.*

After I had an ectopic pregnancy in 2002, it took my partner and I some time to decide to conceive again. The pregnancy was confirmed by blood test and an ultrasound at seven weeks showed a viable pregnancy. Our decision to use an independent midwife was easy, based on our previous experience. We wanted a more woman-orientated approach that recognises that pregnancy is not an illness (without clinical evidence to that effect). We wanted continuity and a relationship with the person responsible for my antenatal care. I was delighted to discover that midwives in independent practice also accompany you during birth and the postnatal period.

*We wanted continuity and a relationship with the person responsible for my antenatal care.*

It was reassuring to ask and to know how many births my midwife had participated in – in particular, how many during training, how many as the primary midwife and how many at home. The additional safety of not travelling during labour was also appealing. Our antenatal visits were at our midwife's home initially, then at our home. The pregnancy was uneventful. My midwife and I discussed the approach to the labour and the birth. I did not want to rush the birth, as I was concerned about the possibility of tearing.

A week before the actual birth I had two hours of regular, mild contractions, four minutes apart. I called my midwife while my partner, mother and sisters helped to prepare for the birth. Soon after the midwife arrived, the contractions stopped and we all went to bed feeling very deflated but hopeful that the labour would start again.

The following week, the contractions started again. I was tired and had planned an early night after a busy day,

but the first pains came as I headed for bed at 9pm. I tried to ignore them as *my* plan was to have a good night's sleep. Recalling the previous week's fizzling labour, I lay down with two hot water bottles and my partner read me Benjamin Hoff's *The Tao of Pooh* to take my mind off the second and third contractions. In between being enlightened in a Taoist way I made up 'hums' to keep in control of the increasing discomfort. It didn't take me long to conclude that *The Tao of Pooh* is unsuitable as a method to counteract the onset of labour!

As the intensity of the contractions seemed to increase very quickly, we contacted the midwife. I walked around the house rocking with each contraction. In between comforting me during the contractions, my partner prepared birth mats, heaters, towels and clothes. There was no noise, no music and dim lighting. After a few strong contractions I hopped into the shower and was singing the words 'I am with you' to the baby. My partner would also reassure me with those words between his errands.

*We wanted a more woman-orientated approach that recognises pregnancy is not an illness.*

The hot water gave me great relief but seemed to speed up dilation. The midwife arrived as I completed my impromptu shower. The next little while is blurry. I recognised my sister's bright red sneakers and green and blue frog pyjamas in the bathroom. We made our way out to the lounge room and I stayed mostly on hands and knees. I rolled my hips and rocked with lots of deep breathing. There was a sensation of pressure and an urge to push but I felt like the baby was not ready to be born just yet. My midwife gave me words of encouragement, saying, 'Do what you want, listen to your body.'

I lay down briefly on the mat, then rose on all fours with the next contraction and pushed a little. There was a 'popping' noise as a gush of water hit the floor. After a very short break, I felt more strong feelings of the baby making its way into the world. I tried to breathe through a strong urge, repeating over and over, 'I'm ready for you to be born, I am ready when you are, baby!' It seemed that after one push I was feeling the baby's head on my perineum. With a second the baby's head was out and the cord moved from around its neck, then a third sustained push and the baby's shoulder and body came all the way out and into the world at 12:45am.

*The Tao of Pooh is unsuitable as a method to counteract the onset of labour!*

We watched as the baby thought about its first breath, a few gentle wipes of the baby's face and it gave a little gasp and a miaow cry. A few minutes later, the placenta was birthed, inspected, and by the afternoon of that very happy birth day, buried under a woody pear (*Xylomelum pyrifforme*).

To me, that was how a normal vaginal delivery should be and it was conducted with care and thoughtful preparation. I really appreciated the one-to-one care that I had and I admire the support, commitment and strength of other midwives who are striving to offer all women the choice and the quality of care that I was fortunate to receive.

**Lisa Metcalfe  
Canberra ACT**