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NEW ZEALAND HOME BIRTH ASSOCIATION

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N E W S L E T T E R - 2

The Second Newsletter of the new National Umbrella Organisation for the Home Birth Associations around New Zealand.

FEATURED INSIDE

Midwives get a pay increase

It has been two years now since we first asked for something to be done and four years since the last time domiciliary midwives received an increase in pay. The increases for the various services offered are between 40 and 45% and should add between $2,000 and $3,000 a year to a domiciliary midwives income. This means that the midwife will be the lucky recipient of a wage between $8,000 and $9,000 a year, while her counterparts in the hospitals can expect to earn around $12,000 a year. The inequity of this situation becomes more readily apparent when one considers that over the past four years wages and prices have increased by over 60% and the midwives have had to accept a dramatically declining standard of income over this period. Now, when they do get a wage increase it doesn't even put them in the position of being underpaid to the extent that they were four years ago - they are worse off, still.

One of the largest increases that the midwives received was a 44% increase for delivery from $25 to $36 per day. This means that the midwives is getting paid about $3 per hour during the period of birth. And what does the doctor get? $75 for the day of birth - that probably amounts to $30 to $40 per hour in most cases.

The question that must concern the Home Birth Association is how long can we afford to let this state of affairs continue? Joan Donley has recently broken her arm. Who is going to look after the deliveries she has to do within the next few weeks? Caroline Young has three young children to bring up and is yet again looking for suitable rental accommodation at a price she can afford. Irene Hogan, as well as doing home deliveries, works in a commune with intellectually handicapped people. Just how long can one afford to be a domiciliary midwife, when you can earn $60 from one shift at St. Helens? We talk about Home Birth as a developing alternative, but if we were to lose two or three of the key midwives around the country who are fighting for our rights far more than they are fighting for their own, then we would be left without an alternative to develop.

I think that we keep on saying this - the time for sentimentality is gone. The government and medical profession are certainly not being sentimental about small

maternity hospitals, about domiciliary midwives pay or anything else that smacks of an alternative to the large base hospitals. All over the country the future of small maternity hospitals is being threatened by the twin argu ments that they are not economic and they are not safe. Doctors are prepared to pull figures out of a hat to support that second argu ment: this time they had to rush off to France to show that small maternity hospitals weren't working there. They could not show that they were not working in New Zealand because they simply don't know what the data are for New Zealand. National Womens has no idea of what are its rates of forceps delivery, induction, caesarian section, analgesia, anaesthesia, episiotomy or even peri-natal mortality over the last three years. The Home Birth Association, with its bunch of amateurs, can work out these things, but the "finest research hospital" in this area of maternity services, cannot.

Even if we could show that the small maternity hospitals were not as safe as the base hospitals, what would that prove? It certainly would not prove that safe effective birth could not be done in small maternity hospitals and it might show that the kind of birth practice in small maternity hospitals was the kind that was suitable only in the large base hospitals. This would be no surprise. After all it is not as if the curriculum for the post graduate diploma in obstetrics and gynaecology teaches too much about normal delivery, or delivery in situations where you do not have foetal monitors and all the other equipment and services of a big base hospital. As for natural delivery, psychoprophylaxis, acupunture and delivery at home, well, do we expect doctors to do themselves out of business? So it is quite possible that small maternity hospitals, whose staff are trained only in base hospital technology and techniques, won't do as well, but that is no reason for closing them down.

And what about the argu ment of economy? It certainly never impressed the medical profession with regard to home birth and they have always done a great "how can you talk about money when peoples' lives are at stake" line whenever they have wanted something for themselves. A recent example of the extent to which they are prepared to spend money to get their point across, was the mercy dash of mother and babe from National Womens to Wellington Maternity Hospital's Intensive Care Unit. At the same time as National Womens were crying out in the press for more staff and more incubators, they had at least two unused incubators in parts of the hospital other than the neo-natal unit. And what about the shortage of staff? What if they encouraged their mothers to keep their babies continuously with them after birth; what if they encouraged rooming-in by fathers (all you need to start is a few double beds); what if they encouraged the early discharge system; and what about encouraging women, midwives and doctors to think about home birth as an alternative. The trouble is that the medical profession are opposed to changes which break down their hierarchy of power or reduce the mechanisation of birth.

We, in the Home Birth Association, must recognise that we cannot afford to wait until the government and the medical profession provide the framework and the finance that will allow home birth to be a secure alternative. The time may come in the not too distant future where to attract and to maintain the services of the domiciliary midwife we have to start putting our money where our mouths are.

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Government Saves Money!

The government has cut out the home assistance grant which allowed home birth mothers to get additional assistance at home for the first two weeks of their new baby's life. Now you have to pay $149 a week for home aid assistance from the Department of Social Welfare. That's an increase of $131 per week. The message is to mums, "stay in hospital; it only costs $700 a week to keep you there." How much did that Health Department computer cost anyway?

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Part II - More from the Panel Discussion at the National Conference .

In the last newsletter we presented the opening statements of the protagonists in the Panel Discussion. Now it is right-of-reply time and the going gets a little rougher. Still, despite the ruffled feathers, there is some evidence of communication going on. To recap, the Panelists were: Dr Andrew MacIntosh (National Women's Hospital), Dr Tony Baird (Auckland Branch of the Obstetrical and Gynaecological Society), Sister Patricia Clark (Nurses' Association), Dr John Grieve (Home Delivery Doctor), Ms Linda Daly-Peoples (a consumer of hospital and home delivery) and Dr Geoff Bridgman (Home Birth Association). In the chair was Pam Daulton.

Chair: This 3 minutes was to give a base on which to discuss the future of home birth. We can now continue the discussion.

Question: Would Mr Baird favour the closing of the Waitakere Hospital which has no facilities for Caesarean Section?

Tony Baird: I favour the acquisition of facilities at Waitakere and the North Shore so that they are capable of coping with all sorts of birth.

Question: Request for Mr T. Baird's reply to Geoff Bridgman's comments.

Tony Baird: I would be happy to give my/the Society's views. The first item is the question of experience in Holland and the U.K. In the U.K. the selection of people and their places of birth is very carefully sorted out, and there is the most magnificent service of domiciliary midwives and excellent G.P.s. I personally have nothing against home births. In Norfolk where I worked for 18 months 25% of births were still done at home. We had a flying squad service from the Norwich base hospital which is central and has excellent facilities. There were midwives available who could stay with the family all the time and the G.P. would come and most of them were very experienced and that sort of set-up I think is superb but we haven't got it here. Traditionally everyone in Britain was born at home because there were not enough hospital beds. Even in the early 70's in the more densely populated areas you had to have a reason to go to hospital rather than the other way around.

The experience in Holland is interesting because the area which is always quoted is a small area and I think I am right in saying that they have big base hospitals very close by.

Geoff Bridgman: We have big base hospitals in Auckland close by.

Tony Baird: You must have been to Holland. It resembles New Zealand in some ways but not as far as geography and population is concerned.

Geoff Bridgman: The thing about Holland is that the statistics available represent all births in Holland just the same as the statistics available represent all births in New Zealand. What has been interesting about Holland is that as hospitalisation has increased there they have been able to show that equivalent cities that have a high percentage of hospitalisation have a poorer performance than those cities that are similar in character which have a low percentage of hospitalisation. So, we have a very well controlled situation here where it is quite clear that Home Birth is an effective alternative. I think that the reasons for not having a Home Birth capability here in Auckland are appalling because it is very cheap service. Why are they spending all this money on up-grading all the hospitals and looking at other alternatives like Birthing Centres, which we agree with to some degree, when they could be, for far less money, providing the kind of service Tony Baird talks about. It is no great problem in terms of money, I assure you..

Linda Daly-Peoples: I am going to bring in the common sense consumer's point of view and draw everybody away from statistics. As a consumer, because that is what you have asked me to represent, I am going to take strong exception to the opinion that we don't have experienced and competent people involved in the Home Birth scene in Auckland.

Pam Daulton: It seems to me that we are talking about two different types of establishments and I come to this as new and uninformed and it seems that some people would like to change the establishment is, and others would like to see it continue in the same direction. I can't see that we are going to get very far if we talk about what the establishment is somewhere else and how successful that is. We have got to talk about what we have got here now and how it changed, in which direction or should it be left as it is.

Question: What standard of back-up services does each member of the panel think would be necessary for Home Birth to be desirable?

Geoff Bridgman: I think the most important area is the positive support from the hospital system so that in the case of transfer there is no animosity, that the patient can carry on having the kind of birth that was intended at home, in hospital. I also think the other thing that is important is that we get a decent standard of remuneration for our midwives.

John Grieve: I agree that as long as one has a base hospital in the reasonable vicinity then that is adequate back-up from the obstetrical point of view. At present of course, we have the patient transferred from the North Shore Hospital for particular problems which may arise. They are transferred to National Womens. As far as I can see, the difference between transferring from a home on the North Shore home and from the North Shore Hospital is very little. Of course, Dr Baird would probably prefer the North Shore Hospital not to exist in its present form. It has had its present form for many years and has provided a reasonable service on the Shore, I think. It would be interesting to compare the figures for perinatal mortality of the N.S. Hospital with National Womens.

Linda Daly-Peoples: Speaking as a consumer: Someone paid by the state to do the housework, someone paid by the state to care for the other children if necessary. Training facilities for parents and all the rest is good for psychological security.

Andrew MacIntosh: (Feeling like the Bogey Man from National Womens) The fact that home deliveries can occur successfully is well demonstrated by the fact that we are all here today and I think there is no argument about that. I couldn't agree more with you two in that what we need is a more positive hospital attitude which I hope we are developing and I would once again endorse what I said earlier in that your approach in telling us what to do will help tremendously and of course all people in Auckland are our patients and are the people we look after when they are ill and this doesn't change under any circumstances whether social circumstances are changed or whatever. So to create a difference there is a pure myth. It's just a feeling of being frightened, of going through the doors of a big white place.

Secondly, domiciliary midwives are of course No. 1 priority, and as Tony Baird has said, the difference between here and Britain is extremely pertinent. You two are comparing a system where domiciliary midwifery and Home Birth has been a norm. Because of the problems which do arise in high risk patients the hospital system has been increased and the sophistication has gone to a level which is undoubtedly overdone. We must not lose the hospital sophistication because there are some patients who benefit tremendously from it, but of course we can become much more sophisticated and provide much more comfort for people as well. So there is no difference between what you two are saying and what I think, but I do think that No. 1 priority is gaining facilities for domiciliary midwives and some contact with the Hospital System.

Patricia Clark: I would like to ask Lyn McLean about her criteria for accepting home birth patients and how she finds back-up facilities in the area in which she works. I did mention the disastrous speed with which things do happen and this is why we have been reluctant to move out into the area and this is one area that does concern the nurses. We have so few people who are skilled as domiciliary midwives and this is a thing we are looking at. I think Lyn McLean had some very valuable things to tell the ad hoc committee when they met.

Tony Baird: I support everything that has been said before about support at home and caring attitudes but one thing I would like to say is that everyone should be booked at a hospital because if a booking is already made a lot of the problems which arise during the transfer (and some of the people who wish to deliver at home are going to have to be transferred) this can be facilitated if all the paper work has been got out of the way, if the person knows where she is going, if she has been there, and all the bogeys have been dispelled. Most of these bogeys people have about not wanting to go to National Womens are caused by ignorance, and the comment I most often hear from the patients of National Womens is that it is really a very nice place and we are very happy here. So, I would like everyone to be booked at the hospital so that further care can be directed at the patient and not to filling in forms.

Lyn McLean: I am a domiciliary midwife from the Wellington area. I think there were interesting comments about the comparison between the New Zealand scene and the English system. I think I am correct in saying that in the past, home birth has been the accepted norm rather than a decision which is made because people think that is where their babies ought to be born and they think that is what is best for them. That is how it is now in New Zealand. We can't really compare these two systems. Obviously one wants to make comparisons to some other country because that is how one gauges how one is getting on and Holland is the obvious place to do that. Prof. Kloosterman has made some interesting comments and research on domiciliary midwifery.

As far as screening goes I think this is the all-important thing. I think I speak for all domiciliary midwives in New Zealand when I say, for example, that we don't accept any patients who smoke but a lot of emphasis is put on good nutrition, and I don't mean just eating lots of meat, cheese, eggs and that sort of think; it is a much more in-depth education on nutrition. I think the whole ante natal education is pretty important but I think we are all pretty strict about our screening processes and so are the G.P.s. involved in home birth. I think this is one of the most important areas.

The other question we were talking about was the transfer to hospital. In this country in my experience doctors are not particularly used to dealing with emergencies of any kind in the home and especially obstetrical emergencies. My personal opinion is that to set up a flying squad and have obstetricians and anaesthetists going around the countryside is not particularly a viable proposition. I think the important thing is to have an ambulance. You have to have a good transport system and it is the ambulance, in my opinion, that you need to have, and in my experience the ambulance service has been more than adequate in transporting people to hospital. I don't think the home is the place for doing any sophisticated obstetric maneouvres such as epidurals or forceps or whatever and in my experience, an ambulance as it is is perfectly adequate in transporting people to hospital.

Someone also mentioned that the baby is at great risk in transporting the patient from one place to another which means that every lady that routinely goes to hospital for delivery is putting her baby at risk by getting from home to hospital and I would agree with that statement in that this is one of the things I have against the alternative Birthing Centres: that I think that if you have to move anywhere in labour you only want to move once and if you chose to have a home birth you may need to move once and if you elect to go to hospital you go once, but if you have to go via an alternative birthing centre, there is no point.

Joan Donley: I want to comment on Dr Baird's comment on booking patients in. I am a domiciliary midwife in Auckland and when we first started we used to book all our patients into St. Helens and on one occasion when we had to transfer a lady, and her chart was there they said "This is our patient. What are you doing delivering our patient at home?" We were called up before the medical superintendant and he told us that he didn't want us to book patients into St. Helens. He preferred that they came in just as emergency cases because they felt that these were "wasted bookings".

Pam Daulton: That sounds like a lack of communications and could be sorted out quite easily.

Tony Baird: I should stress it was a personal view and clearly that problem is an anecdote which I am not doubting and I think was a tragedy for all concerned. I am talking about future, and one should really avoid that kind of confrontation. I am concerned that anyone should be antagonistic either towards me or who I represent. This is not the answer. We, (the OGS) are not your enemies, which is what seems to come through from some of the speakers. It is the Department of Health who provide the services in New Zealand. I happen to believe that they have the duty to provide the best services for the majority of the population and therefore in any system there has to be a hospital and it should be the best kind of hospital. It doesn't mean you can't have home births as well.

Comment: It would be an idea if the people involved in a professional way with birth could attend home births and become familiar with the way births are carried out at home.

Linda Daly-Peoples: I think there is a problem, a difference in that when we talk about what a normal birth is we are talking about home birth, whereas when the hospital personnel and/or people intimately involved with hospital births are speaking for or about it they mean a normal hospital birth. So we are still abnormal. We have to have a bit of faith, not only in the women who make the decisions to have their babies at home, but in the human race as it were; if birth were not the best way for people to be born, perhaps we would have been evolved differently. Somehow, until the 20th century the human race has survived without people being born in hospital and I in no way mean to undermine the value of hospitals in complicated births, especially now that so many of us are having so few children. You can't take the same global view of birth and death perhaps that people used to. If you had 10 children you were expected to lose one.

For some of us normal birth means birth at home and for some it means birth in hospital and that's a bridge you can't cross easily by saying it isn't there.

Pam Daulton: However, I do think the point of this whole discussion is that for people who are going to have children, that either option can be normal for them until they make up their mind which they prefer.

Question: A query about plans to avoid the uncomfortable business of changing beds in second stage labour, in a hospital delivery.

Andrew MacIntosh: We have an increased number of normal deliveries in the 'first stage rooms' now and also we have some new beds on order which make you more comfortable.

Patricia Clark: We have certainly been looking at this for a long time, and agree with you. As most of you know, it is the structure of the building at St. Helens. We would like to do lots of things but we can't. We know it is the concern of many nurses. I am sure the same goes for National Womens and everywhere.

Question: Do the organizations represented here have any direct communication with the consumer, the mother, to find out what she wants and what is desirable in her eyes? Do they have the consumers on their board at the highest level?

Andrew MacIntosh: Have you ever thought how hospital boards were formed? Weren't they formed by consumers? Business men are consumers too. They were originally formed in the way that you imagine. What you say is very relevant, and consumer boards in relation to not only hospitals, but all public services, which we pay very dearly for, are very pertinent. Whether we should form our own consumer board (N.W.) or whether we should form a 'Friends of N.W.' society, we have debated. I am sure we have to do it. We have debated whether we

should form it or whether someone else should form it for us. It becomes very slanted if we form it and personally I would prefer it if someone started it for us. Do remember that the hospital boards did start in exactly the same way as you are proposing now.

Tony Baird: The OGS has not got a consumer committee, no. We have a society for obstetricians and gynaecologists. We are all the time talking to consumers and you have a democratic right not only to elect the Hospital Board, but to choose you doctor and where to go. You discuss it with him in a personal set-up. The OGS society does not formulate policy, we do as we are told, more or less by the Department of Health. We are asked our opinion, but on matters which concern the whole population, so are many other people asked their opinion. What you say is true, the consumers are the only people who matter, we should talk to them.

Pam Daulton: There probably are some groups who can act in this sort of way, e.g. parent centre, perhaps with a particular point of view. Of course, all the societies represented here are societies, whereas the consumer is an individual.

Question: What pressure have the doctors felt from their colleagues for or against home birth?

John Grieve: I personally have felt none. I should have ignored it if I had.

Geoff Bridgman: I would like to comment on this before Dr MacIntosh or Dr Baird, because we do have a letter on record which outlines pressure from a doctor's colleagues, so it is not a hypothetical question, it's not our hostility, it's a real thing.

Andrew MacIntosh: I know the situation which has arisen and I know the letter. All I would say is that some things are more deep and diverse than they appear on the surface.

Tony Baird: I would like to say that doctors are very conscious of putting their own house in order. You must admit this is not the right time to discuss individual labours, individual doctors, or their standards of practice. I could say that the OGS is very concerned with the standard of practice of some of the doctors in this town. We know, just as you know, the evidence of what goes on.

Pam Daulton: I agree we should not get into personal cases. I think we have had an answer from the only person on this panel who is qualified to answer, that is Dr Greive.

Geoff Bridgman: I would like to re-frame that question. Can we be assured that the OGS is going to support competent doctors who are involved in home birth?

Tony Baird: Yes, we are a democratic organisation, not a trade union. We would support anybody who cares primarily for women and their children. One member of the NZOGS is doing a lot of home births in the Waikato. He is accepted and supported and anybody who practised a good standard of obstetrics would be supported, yes.

Question: What does the medical profession feel about the necessity of a doctor being present at the birth. Is it absolutely necessary or is it sufficient for a midwife only to attend the birth?

John Grieve: I personally feel it is essential that a doctor be present at all home births, partly because if he is not there and anything goes amiss it brings the whole home birth movement into disrepute. Having said that, the doctor, while there should keep as low a profile as is humanly possible. Seen as little as possible, and heard not at all.

Tony Baird: The question is a very broad one, and the answer is no. I don't believe it is essential for a doctor to be present at every birth. I think John Grieve is correct that at the moment, given the general climate, it is advisable to have everything possible at home to make sure it goes smoothly, but as long as a doctor is available should any problem arise. I think he is superfluous at a lot of births.

Pam Daulton: I don't think we have got anybody here who can speak for the medical profession as a whole.

Comment: If it is not expected that the doctor be at every delivery, the domiciliary midwife should do more than one antenatal visit at home, and be paid for it.

Lyn McLean: I would like to say that I feel it is essential that G.P.s be involved in home births, otherwise how can we show them what normal birth is all about?

Question: What qualities are essential for a domiciliary midwife?

Geoff Bridgman: She's got to be a very small eater, for a start, because she won't be able to spend much on food with the present pay she is getting. I think she has got to be pretty thick-skinned to withstand the sort of criticism that she will undoubtedly receive from some members of the medical profession, but more than that, she's got to be a sympathetic person, capable of responding to the needs of individual mothers, and she has to be capable of treating each birth as a different event.

John Grieve: I agree.

Linda Daly-Peoples: There is not much to add - patience, I suppose. Anyone dealing with women giving birth should be able to listen to what the women are saying about what they want.

Andrew MacIntosh: As much as you say, and she certainly needs training and experience. Also she very much needs to know her limitations. The last great quality which I think is terribly important is the ability to keep contact with the hospitals in the area. If you are a complete isolationist, you should be working in the back country, not in a suburb where there are other facilities which can also be used.

Patricia Clark: She must have all those qualities just mentioned, but she must certainly be a skilled midwife and experienced. We are still waiting for Lyn McLean's criteria for recruiting domiciliary midwives.

Tony Baird: I would support all those personal qualities, I don't think there is any difference for hospital or domiciliary midwives, and I agree a two-way process would be beneficial. Just as some doctors could benefit from seeing home birth so could some domiciliary midwives benefit from seeing current hospital practice.

Question: (Unintelligible)

Tony Baird: Because of my deficiencies, I prefer to deliver in hospital, and I couldn't spread myself across Auckland, however much I may wish to. As an individual and a society we are open to suggestions and you are the people who are best able to go out and create the facilities for home birth.

Question: How can we go about making home birth more possible without a larger supply of midwives and doctors ..... (also unintelligible).

Andrew MacIntosh: What you say is a very attractive idea but you cannot take a midwife and say 'your 8 hour shift will be in Massey.' It is a very attractive idea to have everything centralised at a hospital. Everything works

in 8 hour shifts and this is what you're objecting to, you can't suddenly turn the midwife off after 8 hours when you are 4cms dilated and send another one out to Massey. It would be a good system but is not practical at the present time.

Comment: Re making domiciliary midwifery a practical and attractive alternative, to the midwives themselves.

Andrew MacIntosh: Our machinery doesn't accommodate change at the present time.

Pam Daulton: You want the medical profession in the hospitals to actively encourage doctors and midwives to work in the community for home birth rather than or as well as in hospital. You are not concerned with the practicalities, you just want the encouragement rather than people being trained to work in hospital. They should be trained to work in the community, is that right?

Andrew MacIntosh: I don't know how the practical problems are solved. These suggestions should be made to the hospital boards. I'm sure we would support it. I think it's a good idea and we are prepared to put your suggestions to our boards but on our own we would have no clout.

Linda Daly-Peoples: They have more clout than we have. One small, practical suggestion - you talked about domiciliary midwives being well trained and experienced, could I suggest that the training of obstetricians and midwives is deficient at the moment in that they never get to see a normal birth. I also had a doctor present at my home birth and it was the first she had seen, and she also made the comment that it was the first normal birth she had seen so could we make the suggestion that as part of their professional training, doctors and midwives be encouraged to attend home births. Presumably it would be dependant upon the domiciliary midwives being prepared to accommodate them, after all, not all of us want our births to be a big social event, and some do. I don't have the paper with me, but patients at National Womens are told it's their duty to make their bodies available for training doctors. Those of us that do feel that it is our duty may be prepared to do that at home as well.

Pam Daulton: If you would like to make that a recommendation, you could go on with that after Tony's gone. He has made a note of it. Would you be prepared to recommend that to the OGS?

Tony Baird: Yes, of course. The hospital based service as it is is inadequate. To break it up would achieve nothing. The aim of the OGS is to accommodate everybody; the aim of the Hospital Board is to provide the best hospital service. The home birth and the hospital birth should run in parallel, not take one, to build the other. We could join forces and build up a good hospital service as will as a good home birth service. Don't decimate one or you'll get two bad services.

Comment: (Unintelligible)

Pam Daulton: You must remember that not all women wish to have their baby at home. You are looking at it from the missionary point of view, which is good for home births because unless there are missionaries there will be no change.

Patricia Clark: I seem to be hearing that we don't see any normal births in hospital, and that's not true. That's how every midwife here today became a midwife, through practising normal births. That's one of the main things we do. Another thing, where are we going to get all the midwives from? It was mentioned that we do 8 hour shifts. Lyn McLean said the other day, she can be on call for two days at a time. Are midwives in this country going to do this? I won't answer it.

Question: put to Tony Baird .....

Tony Baird: That's a good suggestion to put to the Hospital Board or the Department of Health.

Question: A request for Mr Baird to give the name of the obstetrician in the Waikato doing Home Births.

Tony Baird: I said a member of the council of the NZOGS. He appeared at just one meeting. The mere fact that someone thought I said an obstetrician is terribly important. You have to listen carefully, don't you, and not misinterpret comments.

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Cautionary Tale

Some people might accuse us of having a stereotyped view of the medical profession. Something along the lines of, "All politians are insincere"or "all Pakehas have white skin". So just to prove that we have got open minds , we publish this excerpt from the September issue of the Journal of the General Practioners Society, 1980.

On a more serious note, just as the obstetricians and gynaecologists don't want to know anything about natural birth, so do medical schools find the teaching of the profession of General Practice rather irksome. This noble profession, albeit better financially equipped, is also feeling the squeeze. Now read on.

"For over 20 years, I practised obstetrics. Sometimes one, sometimes two, occasionally four or five a week. Once, five in one day.

Used to be a constant headache. Only had to arrange to go out with my wife, or stay home with the kids, or go on holiday, sure as eggs, they would start. They had another trick, too. Come into labour the morning before a birthday party, or a concert, make you think they were going fine, then pop off to sleep for four or five hours and start again just as zero hour approached.

In spite of it all I enjoyed it. The numerous cups of tea in the middle of the night and the pleasant relaxed chat with the night sister after it was all over. Even enjoyed the minor skirmishes when some midwives, obstetric specialists or hospital boards didn't approve of fathers in the labour ward. Made quite a few friends, too, and that helped to make up for the fact that although it was the most demanding, and most worrying part of the practice, it didn't seem to bring in much money. Still, money isn't everything ...

Then the Bonham squeeze started. All in the cause of improved maternal care, of course. And those little green folders marked "Confidential - Maternal Mortality" which indicates, if you read it carefully, that possibly three or four cases a year might be saved, if the most expert help was available at all the right times.

Then the Hospital Board brought in the "high-risk" concept - from Bonham again. So I couldn't book twins, or breeches, or anyone under five feet. Not even supposed to book solo mothers (very high risk).

I found it a hassle to try to explain why I could take some and not others of my patients as maternity cases, and found both competence and confidence dwindling. Had some problems with our local maternity hospital, too - for some years, they would occasionally transfer cases to base hospital, 15 miles away, or to another maternity home in the Board's area, 25 miles away.

Got a bit fed up, too, with a matron who wanted to keep well babies in the nursery "for a rest" for two or three days, while impatient new mothers worked themselves into a frenzy.

Felt quite proud of my record, too. Quite a lot of normal happy babies and a reasonable number of satisfied mums. Of course, every year there would be one or two caesars, and over the years a few babies with talipes, one blue baby, and an anacephalic. Lost about eight babies altogether, mainly from congenital defects, but a couple were real mysteries - lost a lot of sleep over those. One grand multip died after the normal delivery of her twelth, and that was a real disaster.

When I moved to another area, it seemed a good time to give it up. The writing was on the wall - the sun is setting on GP obstetrics - and I was sick of a battle that seemed impossible to win.

Decided to let "the unit" look after all my pregnant patients - that is what all the pressure from the Department is leading to. I didn't realise just what a wise decision that was to prove! Of the past 32 referred cases, the record makes my hair stand on end.

L Sgmt Caesarian Section 7 (23%)
Forcep 3 (10%)
Stillbirths and foetal death 4 (13%)
PPH with retained products 2 (6.6%)
Maternal death 1 (3.3%)
Normal deliveries 17 (53%)

I realise I have had a narrow escape.

If I had booked those cases, the Hospital Board would have withdrawn my right to deliver in their wards.

Makes you think!

May make Prof. Bonham think, too!"

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Birth At Home By Sheila Kitzinger (Oxford University Press) 1979

Book Review

"Having a baby in hospital is a bit like getting on a plane and trusting the pilot. Having a baby at home is like going out in a sailing boat of which you are the captain."

This delightful analogy highlights a humorous, far reaching and honest appraisal of the benefits of "home versus hospital birth". In the book, a large part is directed towards encouraging education so that parents are equipped to make responsible decisions regarding the type of birth best suited to their own needs and the needs of their new baby. Sheila Kitzinger provides an informative and enthusiastic account of home birth. The myths and misconceptions which abound are dispelled by examining the benefits to mother and baby of the home environment. Facts, figures and statistics from countries experienced in home birth are provided to demonstrate these benefits.

Safety is a necessary priority and is discussed in detail. Home birth is not for everyone; mothers and babies at risk are best cared for in well-run, well-equipped and well-staffed hospitals. On the other hand, women enjoying good health, good antenatal care and normal pregnancies can enjoy birth at home. Women making this choice are more likely to ensure they are in tip top physical condition for delivering the healthiest possible babies. They do not smoke, or take harmful drugs. They pay especial attention to their diet and prepare calmly for their labours with the invaluable help of their partners. They are far less likely to need painkilling or hormonal drugs and therefore their babies are more likely to breathe spontaneously and suckle vigorously. Breast-

feeding is easily established and these women have excellent post natal attention from the domiciliary midwives who attend their deliveries.

Sheila Kitzinger is an authority on the process of birth and birthing alternatives, having written several books including 'The Good Birth Guide'. She maintains that provision for home birth should be a vital part of the health services.

She cites several telling examples such as "five times more babies have difficulty breathing in hospital than at home" culled from official medical sources in the U.K. and laments that "midwives often get little opportunity to see truly normal childbirth nowadays". Particular emphasis is placed on the vital mother-child relationship in those crucial first few hours - achieved naturally at home - but distressingly uncommon in hospital where there is often "the prescribed few minutes for officially sanctioned bonding" - perhaps the best phrase in the book for summing up hospital authorities attitudes.

Although 'Birth at Home' is concerned with information and education, it contains also an insuppressible expression of joy and enthusiasm for the celebration of life. The author has enjoyed five home births herself and includes the experiences of other home deliverers in the text. Two chapters are dedicated to the needs of the father (who after all deserves more thought and attention than he often gets) and other children in the family. The father's assistance and participation in the birth are beautifully described.

'Birth is not only the dramatic climax of pregnancy. It is not simply the process of getting a baby out of a woman's body. It is experience which can have significance and intrinsic value for the woman, the father of the child, and the whole family. The meaning that birth has for the couple who are becoming parents and their active participation in it may be important for their development as a man and woman able to father and mother and to derive pleasure from it.'

'Bonding of mother, father and baby is not just a question of what happens in the minutes <u>after</u> birth, but of the whole environment in which labour takes place.'

In many areas of health care and particularly the care of pregnant women, the conventional relationships between doctors and 'patients' need to be reviewed. There is a strong case for more participation in, and responsibility for, one's health. A relationship which takes the form of partnership between pregnant women and the medical profession is indicated. Birth is far too important a cultural and emotional event to be allocated to hospital management before advantages, disadvantages and alternatives are considered.

Pauline Proud
Tony Marks

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<u>Safer to have your baby in Hospital?</u>

In Sheila Kitzinger's new book "Birth at Home" she makes a statement about the safety of home birth which should give us pause for thought:

> "Every woman having a baby at home should realise that there is a small, but nevertheless real additional risk compared with birth in a well-equipped, well-run, and well-staffed hospital. Unforseen emergencies can occur, even when everything has been apparently normal throughout the pregnancy, which only a hospital can deal with."

This statement, coming as it does from a person who is committed to Home Birth and who has recently edited a book of studies which gives scientific testament as to the safety of home birth, raises two important points:

1. Is there new evidence which suggests that hospital births are safer? No. In her chapter on safety Ms. Kitzinger goes through the evidence on safety presenting the familiar material on safety. She reiterates, for example, that where home delivery is practised as an established alternative (for example in Holland and in Great Britain) the most recently available statistics shows that the peri-natal mortality rate is about 4 per 1,000. She also mentions that in Holland that the percentage of babies sent to special institutions because of brain damage is 1.5 per 1,000 compared with 5.4 per 1,000 in the United States. She argues that the strongest causal factor for the lowering of peri-natal mortality around the world has been improvements in socio-economic standards rather than the means of or the place of birth. She concludes that "the arguement about home versus hospital birth can never be resolved at a present state of knowledge."

2. What if hospitals were safer? The stock and trade of the medical profession is saving lives. There is no doubt that there are some hospitals in the world where the peri-natal mortality rate is extremely low and there are some hospital systems, such as the Swedish one which produced very low rates of peri-natal mortality overall However, safety as a goal cannot be considered on its own. As Kitzinger states,

   " It is not just a matter of pushing out a live baby, a question of mere survival of mother and child,but of a quality of life that follows."

   It is also a matter of economics too. The argu ment that improvement in socio-economic standards has lead to a lowering of the peri-natal mortality rate can be applied to almost any area of health. Some will claim that the development of a system of plumbing and sewerage disposal has done far more for human health than the invention of penicillin. The Health Services use an enormous amount of money ($1,000,000,000 last year) much of which might lead to far greater health benefits if it was spent on the environment, on job creation and on education.

   So if we know that we have got a safe, satisfying way of having birth, like home birth, why do we need to spend millions and millions of dollars making hospitals just as safe and satisfying? And then spend millions more making them safer still. After all, it would only cost the government another $30,000 per year to make domiciliary midwifery an attractive financial proposition.

"Health Care in New Zealand costs over $800,000,000 and a staggering 70% of that is spent in the hospitals. Well over half of that, $560,000,000 or so, is spent on patients in the last two years of their lives."

Dr Randall Elliott
Listner 8th February 1973

Geoff Bridgman

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More Submissions

Maternity Services Committee receives another broadside, this time from Lyn McLean. Here are the major points:

It has been my experience over the past two years as a domiciliary midwife, to find that both lay people and medical and nursing professionals have difficulty in discussing domiciliary midwifery objectively. Rather, as with abortion, it is debated at an emotive and personal level. I trust that members of the Committee are above reproach in this area, and that 'Obstetrics and the Winds of Change' is not their example of unbiased dialogue.

It should be remembered that maternity services are provided for the consumer, not the professional, and on that basis it is important that domiciliary midwifery be considered as part of the total obstetric service; not as something 'alternative', different or separate, to be 'approved' or'disapproved' by any official person or body. It is not for the Committee to moralise on this issue, but to ensure that the consumer is provided with a safe and unprejudiced service.

Most people, especially nursing, midwifery, and medical professionals, are grossly ill-informed about planned home confinement, and indeed it is probable that not one member of the Committee has seen a prepared home birth as it is in New Zealand.

It is therefore important that the people making decisions for the future, on behalf of parents and domiciliary midwives, avail themselves of the facts concerning planned home birth in this country, and that decisions are not based on hearsay, personal feelings, or other country's situations. For example, in England and Scotland, up until recently, home birth was the accepted tradition; whereas in New Zealand, it is an informed choice made by parents who both want, and are medically and obstetrically able, to have their baby's at home with safety.

In my view, the Committee have a big responsibility to ensure that maternity options remain open, especially at a time when choices are narrowing and centralisation is taking control. It is important that the demands of the minority, as well as the majority, are catered for.

Most people are now wanting to be responsible for their own health. An increasing number of people are realising the importance of sound nutrition and not smoking, and are aware of the deleterious affects of taking drugs, especially during pregnancy and labour, when their short and long term adverse affects on the foetus are not fully known or heeded.

More people want to share the responsibility for the birth of their child. That is to say, more parents wish to be involved in the decision-making about their pregnancy, birth and baby, rather than to automatically defer responsibility to a medical practitioner and Hospital Board, who invariably are concerned primarily with disease and disorder, rather than health and natural physiological function. Although the medical practitioner has the final say as to who is a suitable home birth candidate and who is not, responsibility is shared between the doctor, the midwife, and the parents. In my opinion, the Committee has a responsibility to see that parents' rights in this matter are preserved.

Politics & Statistics

Childbirth is a political issue. With the 'specialists' striving for monopoly over reproduction, general practitioners are being squeezed out of obstetrics, and midwives are unknowingly being phased out and replaced with technical institute-trained doctors' assistants; and all under the guise of 'safety'.

Good infant and maternal mortality and morbidity rates are not dependent on the degree of hospitalization. In fact the higher the hospitalization rate, the higher the infant mortality rates appear to be. For example, Holland has always been impressive with their favourable infant mortality rates, and yet over 50%

of their babies are born at home. America, with its 100% hospitalization policy has one of the worst records for infant mortality of all the developed countries. New Zealand's figures are hardly impressive either.

It is important to realise that what is invaluable to the abnormal, does not 'improve' on the normal. Unnecessary interference is a serious threat to unsuspecting mothers and babies.

I strongly urge the Maternity Services Committee not to just maintain the status quo in this matter, but to help domiciliary midwives to provide the kind of service we are trying to give under somewhat difficult conditions.

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News from the Regional Associations

The National newsletter is now sent to over 450 people around the country. Details are:

Auckland	220
Hamilton	30
New Plymouth	15
Manawatu	20
Wellington	85
Nelson	21
Christchurch	30
Dunedin	37

However, we are not getting enough regional news back. So please make an effort and send copy about your association for the next newsletter. Not all was lost, however, Manawatu did send us this report.

News from Manawatu

The Manawatu Branch of the N.Z.H.B.A. will be one year old at the end of November, 1980. Initial moves to form the group began in August 1979 and our midwife was registered by the end of November. We have had a tremendously successful year owing to the efforts of our midwife, Linley Mcfarland. Linley has worked very hard to liaise with Doctors and hospital staff so that we enjoy good relationships with our G.P.s and the hospital. Booking in presents no problems and nor will transfers when the need may arise. We have moved from 1 co-operative G.P. in May 1980 to 5 as of September.

We will have shared 9 births at home in our first year of operation. On Sept. 27th we enjoyed a pot-luck lunch at the Rolston homestead for all our babies and their families and our pregnant Mums and Dads. It was rewarding to see our first baby nearly a year old and then our latest of only 2 weeks. This type of function serves us as a good informal way of meeting the midwife and sharing ideas on all aspects of H.B. Our main aim as a whole group is still to inform people that Home Birth is an available and valuable option and to support our midwife. To this end we have a talk back planned on the local radio station on 7th Oct. and a futher public meeting in November.

We hope this report illustrates our organisation and co-operation with existing services.

Alison Brebner

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Subscriptions

(Financial Members to ignore the following coarse remarks.)

No jokes this time, no humourous asides. It is no longer a laughing matter that your subscription is overdue. If you want to be accepted back into decent peoples' homes fill in the form below, don't forget to add a cheque for $5 (as if you would!), and post to the Secretary of your local HBA. Addresses shown below.

NAMES: .....

ADDRESS: .....

..... PHONE:.....

To the Secretary of the ..... Branch of the New Zealand Home Birth Association, please find enclosed $5.00 for the 1980-81 subscription to the Association.

SIGNED .....

Auckland Branch: P.O. Box 7093, Wellesley Street, AUCKLAND
Christchurch Branch: 3 Clifton Bay Road, Sumner, CHRISTCHURCH
Dunedin Branch: P.O. Box 6124, DUNEDIN
Manawatu Branch: 36 Duke Street, FEILDING
Nelson Branch: Riverside Community, NELSON
Taranaki Branch: Katikara Farm, RD 4, Carrington Road, NEW PLYMOUTH
Wellington Branch: 11 Te Aroha Street, HAMILTON
Postal address of NZHBA and Executive: P.O. Box 7093, Wellesley Street, AUCKLAND

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January Issue

Deadline for this issue is 20th of January. Utter your thoughts in writing without delay and send to: The Editor,
NZHBA Newsletter,
P.O. Box 7093,
Wellesley Street,
AUCKLAND 1.

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