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HOMEBIRTH AUSTRALIA

ADELAIDE May 18,19.20,21/1990

The 11th Homebirth Australia Conference was stimulating, with a wide range of very interesting speakers and workshops.

The venue at the secluded St Pauls Retreat, part of a monastary at the base of the Adelaide hills comfortably accomodated the more than 70 mothers, children and midwives who lived-in.

The organisation was extremely efficient. Congratulations to the hard-working team who handled the live-ins plus about 130 other daily registrations.

The weather was sunny, but cold. It was great to renew acquaintances and establish new ones. There were many midwives presnet - domiciliary, from birth centres and from hospitals.

One of the keynote speakers was Beatrijs Smulders, vice president of the Dutch Association of Midwives. She told us about maternity care in Holland. Other stimulating speakers were Maureen Minchin, author of 'Breastfeeding Matters' and 'Food for Thought'; and Nicky Leap, an independent midwife in England for seven years.

However, unity was not always apparent! At the AGM, the constitution to incorporate was finally presented. The decision to incorporate, hopefully to improve funding options, was made at the Bunbury, WA Conference, 1987. In adopting the constitution it was decided that no midwives should be elected onto the National Executive, although a midwife could be co-opted. This was vehemently opposed by Elaine Davis, SRM and founder of the Home Midwifery Association, Queensland. She stredded that mothers and midwives had to work together to make effect ve changes in maternity care.

The discord which has been rumbling for some time seems to have come to a head over an editorial by Dell Horey and the analysis of the 1988 Homebirth Australia statistics by Hilda Bastian in Homebirth Australia Newsletter no 23, summer 1989. This saw the mortality rate as "a cause for concern". The PNMR was 9.2/1000 (national 10.6/1000 - 1987). This comprised 7 fetal deaths and 4 neonatal deaths out of 1197 planned home births. Two died in utero prior to labour. Since the criteria for assessment was that home was the intended place of birth at the onset of labour, it is questionable if these two should have been included. Five died during labour, one of which was hydrocephalic; four died postnatally one of which was trisomy 13 and one a SIDS at day 14.

In the Communique of the Independently Practising Midwives, Maggie Lecky-Thompson editorialised "statistics need expert analysis. It is inappropriate to take one set of figures and compare them to another set of figures that are thousands of times larger than our homebirth sample and then to conclude that the percentages have some similarities, and therefore, homebirth practises must be strongly suspect. To be truly accountable we need to keep a clear perspective of what history has to teach us and not to panic because numbers can be twisted very easily when we allow doubts about our newly acquired beliefs to take root".

John Stevenson, still fighting for re-registration with no support from HOmebirth Australia, also challenged the "several mistaken assumptions.....and untenable conclusions" in a letter to the editor. (Newsletter no 24, autumn 1990). He wrote, "Because Hilda has set out the latest statistics elaborately and expansively with a multiplicity of tables, after the fashion of modern medical

journals, does not mean there is any more of a message in them, nor that Hilda is qualified to find any message in them". In analysing stats "a sense of proportion is essential", he said. He was also concerned at the suggestion that "midwives need to improve their level of skill and increase their training" He found this "impertinent and unwelcome....one thing homebirth midwives know a lot about is responsibility.....this should be acknowledged and confirmed...: He cautioned that "it is dangerously unrealistic to imagine that establishment obstetricians will ever take notice of our statistics, no matter how good they are.... The homebirth movement should keep a long arm's distance from statisticians employed by the obstetrical establishment".

In reply, Hilda suggested that John was guilty of "professional chauvinism" saying that "many healthcare practitioners find the prospect of accountability to their "patients" irksome in the extreme, consumers are increasingly exercising their right to critically oppose healthcare services according to their own expectations and values".

The Australian homebirth (independent) midwives have enough problems without this. The Australian Medical Association (AMA) at a Federal Council meeting, March 1990, in Canberra approved a policy which "opposes home births and independent midwifery". Said Dr Peter Joseph (SA),"We have got doctors running out of our ears, and here we are giving work back to people who aren't even properly trained". Dr Bruce Shepherd, NSW surgeon, recently elected president of AMA, felt that any latitude to the proponents of home birthing would seriously undermine the AMA's position of opposition. This was reported under 'Doctors Facing a Midwife Crisis' in Australian Medicine 2.4.90

The homebirth movement is seen as "a vociferous and publicity hungry group" (1) Peter Wilkins, Federal AMA Assistant Secretary General told Hilda at a working party that there was no role for consumers in the development of policy, "it was simply a matter of science" (HBA Newsletter no 24) They could be consulted in such issues as wallpaper!

The panic arose following transfer of a "failed home birth" to the Royal Canberra hospital, August 1989. This was a case of an undiagnosed primip breech who refused the services of the available honorary obstetrician, who, the doctors claim was told to "fuck off" by the woman and was physically barred from the delivery room by her partner. The AMA wants to ensure that such an event doesn't recur. (Australian Medicine, vol 1, Dec 1/18, 1989)

The only accomodation that the AMA is prepared to cede to a hospital alternative is a birthing centre located in or within the grounds of a maternity hospital, with midwives working under medical supervision. In a policy report the Australian College of O&G strongly opposes midwives operating independently of medical or hospital services. (Australian Medicine, vol 1) To undermine independent midwives the AMA plans to lobby both the government and the opposition against Medicare funding for home births conducted by unsupervised midwives.

It has also decreed that "higher levels of accredited training, expertise and certified experience, above those required for hospital midwives" should be necessary for independent midwives.

The Australian College of Midwives Inc (ACMI) has prepared a document on accreditation of midwives which was accepted at the

ACMI Conference in Darwin in 1989. Since then, the Department of Health, NSW, has asked ACMI to facilitate this process of accrediting independent midwives to various public hospitals. ACMI has asked the independent midwives to make contributions that they would like to see in a Grandmother clause, which would allow exemptions for specific training for midwives already practising.

At Conference this, and other issues were discussed by the Australian Society of Independent Midwives (ASIM) which was launched in September 1989 by the Sydney independent midwives to formulate policy on community midwifery. "We need to acknowledge and assist our colleagues (ACMI) outside of the homebirth community with the recognition that homebirth midwives are different to hospital midwives, they have a different approach and face different problems and responsibilities". (Maggie Lecky-Thompson, Communique, vl, no 4, spring 1989)

On the issue of accreditation, it was recognised that this was necessary in the interests of obtaining

contracts for hospital privileges
proposed government funding for home births
indemnity insurance.

However, concerns were expressed that accreditation would:

* set up a two-tier midwifery system
* further institutionalise childbirth as the regulations as presented were in the interests of obstetricians, hospital midwives and government leaders. Independent midwives shouldn't buy into the doctors' values system and numbers game.
* put the stamp of approval on the present training of midwives
* the rigid requirements and regulations would threaten midwifery independence /freedom and compromise women's choices. One midwife commented that she wouldn't want to be as highly regulated as Dutch midwives.

Some felt that preparing criteria for the grandmother clause was doing the job (with no remuneration) that should be inherent in midwifery education. It would be more appropriate to improve midwifery training by including community experience and to prepare midwives for registration which would include accreditation. Direct entry midwifery training was endorsed.

The ACMI accreditation form was seen to be "not relevant to domiciliary practice", "rubbish", would be more relevant if based on the Chalmers/Enkin tome (Effective Care in Pregnancy and Childbirth, Iaian Chalmers, Murrary Enkin, Marc Keirse, Oxford University Press, 1989, 2 volumes, 1478 pp hbk £225).

After much discussion the ACMI accreditation document was rejected in its present form and the following remit was agreed to:

THAT in the development of the ACMI accreditation programme the ASIM urges that a working party be established comprising independent midwives, consumers and College members. We recommend that this programme should be based on the WHO definition of a midwife and other relevant WHO documents.

It was also recommended that the ACMI make provision for consumer membership.

The controversial issue of lay/traditional midwives was briefly discussed. There are 29 lay (unregistered) midwives who attend 13% of the home births. (Home Births in Australia 1985-1987, Hilda

Bastian & Paul Lancaster, National Perinatal Statistics Unit/ Homebirth Australia, ISSN 1034-7178). According to Homebirth Australia Newsletter no 34, the NSW Department of Health is investigating eight home births attended by unregistered midwives where the baby had either died or suffered serious disability. It is illegal for unregistered midwives to call themselves birth attendants or to attend home births except in an emergency.

'Retractor' in the New Zealand Doctor (21 May 1990) writes about midwives and home birth issues in Sydney and refers to a case where the attendant tried to resuscitate the baby by placing a crystal on its chest and chanting a mantra - "the same mantra they chanted at the funeral".

Despite this sort of adverse publicity ASIM is supportive of the unregistered midwife and recognises her plight. ASIM sees that midwifery training can be acquired in a variety of forms and that the lay midwives cannot be left out in the cold. Maggie points out (Communique vol 1 no 4) that at one time the hospital midwives saw the domiciliary midwives threatening their status; now many homebirth midwives feel that the presence of lay midwives is a barrier to acceptance of themselves.

At the Conference ASIM meeting it was suggested that there be an exam for all midwives in order to establish their basic standards.

Indemnity insurance is another controversial issue. While seen as being "part and parcel of becoming accredited for hospital privileges, whilst we continue to buy professional indemnity, we are laying bets with the insurance companies that we will be sued" (Communique vol 2 no 2)
At last year's Homebirth Australia Conference, Sydney, Patricia Staunton, NSW Nurses Association presented a paper on the legal aspects of homebirth in which she pointed out that "until you can manage to educate the wider community that what you are about is not only legitimate but reasonable and proper and acceptable as an alternative, then you will be judged by the wider community standards. In the area of homebirth you will be judged, of course, on the basis of what is reasonable by medical practitioners and nurse-midwives generally from the hospital environment" i.e. by the standards of a hospital oriented nurse-midwife who is coming generally from a totally different perspective.

In a court the midwife will be judged by the standards that the legal system at the moment sees is reasonable and acceptable, and that is largely coming from the institutional medical model of health care which, of course, you so emphatically reject. (Homebirth Australia Newsletter no 23)

In her courageous and inimitable way Maggie presents another perspective. She tells midwives not to get "sucked in". She says, "I know the fear of death and litigation is never far away But as a homebirth midwife you have chosen to walk on the edge, the fast lane, whatever you want to call it....it's not meant to be easy, and attempts to make it as cushy as it was in hospital practice will put a 'For Sale' sign on our integrity and growing intuitive process" (Communique vol 1 no 4)

Despite the conflicts and medical threats, all is not doom and gloom. Midwives have the support of MAMA (Mothers & Midwives Action) a dynamic and growing organisation which promotes the interests and needs of women haveing children and the midwives who care for them - wherever they work.

Melbourne, where their Homebirth Support Group folded after the trauma of John Stevenson's deregistration, has a very strong MAMA. They were well represented at Conference and offered to host the Homebirth Australia Conference for 1991. Their address is: MAMA Inc, P.O. Box 298, North Carlton, Vic 3054.

A further development is the $6.4 million budgeted by the Commonwealth government for alternative birthing practices to be spread over four years. There are fears that this will be used to set up birthing centres. According to Senator Rosemary Cowley Canberra is negotiating with individual states re distribution of the funds, but this entails issues relating to the training of midwives, indemnity insurance, accreditation etc.

These negotiations will no doubt be based on the National Health & Medical Research Council's (NHMRC) 1989 follow-up on Homebirth (follow-up to the 1987 statement which said there was no scientific evidence to justify the concern about the safety of home births). This 'supplementary' document amended under pressure from the Royal Australian College of O&G (RACOG) "clarifies" the NHMRC's position and acknowledges the position of the RACOG which "does not accept the premise that homebirths are a safe alternative, nor does it support the concept of midwives operating independently of medical and/or hospital services". RACOG does cede "the right of women to choose to give birth at home" but considers that the College "has a clear responsibility to support and develop measures" to ensure "maximum safety".

Now NHMRC has outlined 'Appropriate Care for Homebirth' which includes access to an integrated team of appropriately trained health professionals with adequate resources; women should be booked in to a hospital with appropriate arrangements for transfer; all newborns should be examined within the first week by a medical practitioner; improved communication between health professionals; development of standard guidelines, systems of accreditation and quality assurance programmes; notification of all planned homebirths to State perinatal data collection units and will recognise non-registered attendants as support persons only.

During the Canberra crisis the AMA saw the RACOG as having abdicated its responsibility leaving all the shit slinging to the AMA. As well as the fact that that individual doctors and obstetricians are supportive of homebirth, there is obviously some division between the AMA and RACOG.

Dr Andrew Ramsay who has been attending homebirths for 14 years in Adelaide spoke at Conference about the relationships between homebirth midwives and parents and hospitals. As a member of the perinatal mortality review committee of the S.A. Health Commission, he was of the opinion that in the case of babes that were asphyxiated at birth, it was not the place of birth that was the problem, but the lack of unity and tension between members of the health care team.

Other bits & pieces

In view of the N.Z. controversy over vitamin K for newborns, it was interesting to hear Maureen Minchin state that colostrum is high in vit K. According to our dogmatists, only cow's milk has high vit K levels. But, as one speaker said, "Let sleeping dogmas lie"!

Melbourne independent midwives make a differentiation between midwives who support women and those who support doctors referring to the former as 'midwives' and the latter as 'midmeds'.

South Australia is planning to introduce legislation to place a levy on disposable nappies and use this to provide a free nappy service for the first few weeks for every woman who has a baby.

The Second International Home Birth Conference - 'Reclaiming our Heritage & Creating our Future - will be held in Sydney in Oct/Nov 1992 over five days. There is a call for papers. Contact: Conference Secretariate, P.O. Box 341, Balgawlah 2093

Fax 612 949 6409.

Finally, a brief summary of the 1985-1987 homebirth stats referred to earlier.

There were 3400 planned home births. Transfers - 293 (8.6%) during labour, mostly for lack of progress; overall transfers - maternal & neonatal during labour & after the birth - 13.6%; c/s 2.2%; assisted vaginal births 3.1%, episiotomy 4.6%, sutured tears 22.4%; pph - 9.9%, primips 30.8%; PNMR - 20 = 5.9/1000.

1)Carter W. Regional Representatives Report Nov 1989; Qld AMA Bulletin, Dec 1989 p10)

Beatrijs Smulders

In Holland, birth is not a "big deal" according to Beatrijs. While close to 37% of births take place at home, transfer to hospital is accepted as it is recognised that every birth does not work. Also, the hospitals give women what they want. In fact, doctors and hospitals are required to adapt their practice to suit women.

Another factor which makes transfer non-traumatic is that obstetricians and midwives respect and recognise each other's skills. Obstetricians study for action, not to sit on their hands, so they are not suitable to handle normal birth. This demarcation of tasks protects women and reinforces midwives.

There is healthy conpetition between obstetricians and midwives. If an obstetrician is seen to be doing too many forceps deliveries or is too quick to do a c/s, the midwife does not refer to him until he gets the message. On the other hand, if the midwife transfers too late, she is not welcome in the hospital. In 1985 the c/s rate was 7.7%, vacuum and forceps deliveries 7.7% and PNMR 9.8/1000.

Epidurals are not done in Holland. Neither are midwives allowed to give pain killers - it is considered pathology to give a pain killer. Midwives have to use their skills.

In Holland, home birth is institutionalised. This developed because doctors didn't want to attend home births as there was no money in it and midwives didn't want to go into hospitals, so the government pushed for home births. Medicalisation of childbirth came later to Holland. In places where medicalisation came earlier, there was consentration of improvements to hospitals. Institutionalised home birth has the value of influencing and moderating the system. When women are subjected to medical procedures during childbirth they become dependent and midwives become less autonomous.

The midwife has been able to survive in Holland becasue of the belief that birth is normal. Obstetricians want to change this. Another factor that favours the midwife's survival is that she is not a nurse. Nurses function in the heirarchy of a hospital, midwives function in the independent field. If a nurse wants to become a midwife she has to retrain to "shake off her bad habits". Midwifery training is three full years which is the equivalant of four academic years. Medical students have to do 10 home births with a midwife.

Maternity aids are called by the midwife when the woman is about 8 cm dilated. She helps the midwife at the birth and cleans up after. She provides eight days of postnatal care and home help, but the midwife calls daily to check the aid's records and make sure all is well. In 1985, 92.6% of women had maternity home help; only 7.4% had other help.

The midwife is responsible for prenatal care, birth and supervision of the lying-in period. "No one" said Beatrijs "does the prenatal care as well as the one who is responsible for the birth".

The Dutch government has protected the midwife by guaranteeing her income and by fully subsidising the maternity aid system. They have also had supportive obstetricians like Professor Kloosterman, and now Professor Travers.

The Dutch system of screening is based on the Medical Indications List, recently revised. It is to protect the low risk woman from the high risk practitioner - there is a shortage of midwives (only 1200) and too many obstetricians. The government has asked for restrictions on the "breeding"(training) of obstetricians. Obstetricians are paid by the insurance on the basis of the List and on advice or referral from the midwife. The obstetricians went "berzerk" over these moves.

Beatrijs showed a couple of slides - one of a large number of rosy apples with a couple of yellow pears, and another of mainly yellow pears and a couple of rosy apples. She explained that midwives are used to seeing rosy apples (healthy women) and quickly spot a yellow pear; obstetricians are used to seeing yellow pears so when a rosy apple turns up they are suspicious of it.

Beatrijs works in a practice in Amsterdam with two other midwives which she bought into for $40,000. (There is no problem for a midwife to get a bank loan for this purpose). They do approx 40 births per month. All hospitals are open to midwives to attend to women who rent rooms there. Obstetric nurses are there to assist midwives and obstetricians. There are 28 male midwives in Holland.

Joan Donley 1 June 1990.

11th National Homebirth Conference 1990

Unity in Birth

The Advertiser

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New attitudes mean more homebirths

By Medical Writer
BARRY HAILSTONE

There had been a swing towards homebirths in New Zealand resulting from a change in women's attitudes towards obstetricians and the homebirth process, a leading NZ domiciliary midwife said yesterday.

Ms Joan Donley told a national homebirth conference in Adelaide that midwives delivered 900 babies in NZ last year, almost three times the number in 1984.

Ms Donley, who has played an important part in raising the public profile of midwives in NZ, said more women were objecting to medical intervention in childbirth and that the safety of homebirth was no longer a major concern.

The increasing number of women experiencing a safe homebirth was changing the belief that it was an unsafe practice.

"The attitude of hospitals to midwives is changing and we have a college of midwives which has also raised our status."

She told about 200 delegates to the 11th National Homebirth Conference at St Pauls Retreat, Glen Osmond, that the image of obstetricians had been tarnished in NZ as a result of the Cartwright Inquiry into deaths relating to cervical cancer.

[The NZ Government appointed Judge Sylvia Cartwright in June, 1987, to investigate allegations that hundreds of women with signs of cervical cancer were not treated as part of a 25-year experiment by an Auckland gynecologist who did not treat women with pre-cancerous symptoms detected by standard smear because he believed it was unnecessary surgery. Eight women died and many more ended up with terminal cancer.]

Ms Donley said the inquiry had raised issues such as informed consent, patients' rights and patients' options and this had given issues relating to homebirth a higher profile.

The cost-effectiveness of midwives was another factor that was contributing to their increased use.

In NZ, midwives were paid by the State with fees that discouraged the duplication of care.

The four-day conference will also discuss the Federal Goverment's $6.44 million in assistance to the States and Territories to help promote improved choice and greater cost-effectiveness in birthing services.