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REPORT FROM MEETING OF HOMEBIRTH PRACTITIONERS, HOMEBIRTH ASSOCIATION MEMBERS WITH ANNE NIGHTINGALE & HELEN NAGLES.

Homebirth GPs in the Central Auckland area were recently advised that so-called 'double' bookings' were to "cease", and in case of transfer the woman would be assessed by a consultant - either the head of the team of the day (for free but subjecting her to becoming 'clinical material') or by a private obstetrician (if she can afford the fee). - Hobsons's choice!

Since 1975 obstetricians have been trying to 'control' (read eliminate) home births - see background article in Auckland HBA Newsletter No 50. This arbitrary decision is but one more attempt at control. The homebirth practitioners and the women opting for home births were outraged by this edict. Following numeerous letters of protest a meeting was arranged with Miss Nightingale, Manager of Maternity & Neonatal Services, NWH & Helen Nagles, Chairperson of the Board's Complaints Committee which endorsed the decision. This meeting took place on 1 July, facilitated by Helen Brownlee and attended by more than 50 homebirth supporters plus the midwives from DU 1 & 2 brought by Miss Nightingale.

Anne Nightingale presented her rationale for this decision - i.e. "concern for the safety of mothers and their babies", and if some development affects the place of booking, eg transfer, this changes the situation and requires consultation with an obstetrician. (Two weeks prior to our meeting Nightingale wrote to the NZ College of Midwives, Auckland Region asking that "decision to change booked place of birth - B (Specialist Consultation) i.e. transfer in labour" be added to the Scope of Practice document prepared by College members. This request was resolutely rejected at a General Meeting.)

Nightingale maintained that this decision arose out of issues concerning roles, management delays and outcome of a particular case which she was not prepared to discuss. Complaints about this case were in fact made to the Board and to the Nursing Council. The Nursing Council gave the DM the opportunity to defend herself at the Preliminary Inquiry and the case was dismissed.

Although the right to defend oneself against charges is a basic legal right in this country, the Board did not give the DM an opportunity to present her case. When the DM challenged Helen Nagles on this after the meeting, Nagles said that the Board had no jurisdiction over the DM but added that this complaint brought issues to a head and gave Nightingale an opportunity to introduce a policy which she had been wanting to do for some time. (Interesting comment!)

In Bonham's day opposition to home birth was open. Today, lip service is paid to "the place for home births" while the opposition is hidden behind the "safety of mother and baby". What became very clear at this meeting was the differences between home birth & hospital practitioners when it came to assessing 'safety'. The hospital based midwives only felt comfortable when 'safety' was determined by electronic fetal heart monitoring (EFHM) and were highly critical of the home birthers who resisted having a clip screwed into their baby's scalp. They were even more critical of DMs who supported women in their resistance and felt we should have to do 'time inside' - become 'medicalised'.

Home birth practitioners, on the other hand, were quite comfortable with assessment of the fetal heart by ausculation, and are, in fact supported in this by numerous scientific studies:

* New England Medical Jnl 1.3.1990, pp 588-593 - "....in eight randomised clinical trials perinatal morbidity was not reduced with electronic fetal monitoring. Little direct experimental evidence has been put forward to support or refute assertions that electronic fetal monitoring reduces the risk of neurologic disorders....We found that as compared with a structured program of periodic ausculation, electronic fetal monitoring did not reduce perinatal morbidity or other adverse perinatal outcomes.....
  "The incidence of cerebral palsy was higher in the electronically monitored group - 20% as compared with 8% in the group that was monitored by ausculation.....
  "Clearly, the hoped-for benefit from intrapartum electronic fetal monitoring has not been realized. It is unfortunate that randomized, controlled trials were not carried out before this form of technology became universally applied."

* Prior to that - 1987 - Dr Parer, one of the world's leading experts in cardiology was "perplexed and disturbed" by the results of nine prospective controlled trials of electronic fetal monitoring which indicated little or no benefit of electronic fetal monitoring when compared with careful ausculation. (Birth, vol 14, no 3, Sept 1987, p 114)

Home birth practitioners keep up with the latest medical literature and developments. They are therefore well aware of the relationship between a stressed mother and a distressed baby. As the hospital practitioners see EFHM as the key to safety, the distress experienced and expressed by the mother is seen to be due to her uncooperative attitude, her selfishness and her lack of information. These fundamental philosophical differences explain the deterioration of the

previous good relationship which had developed between NWH DU midwives & home birth practitioners.

Although refusal to allow "double booking" was a Board decision, GPs at North Shore & Middlemore had not been advised that the practice of booking home birth women into hospital had been discontinued. Helen Nagles appeared to be surprised to learn that this was the case.

Jenny Johnston (ex-Wn DM) was at this meeting. She detailed the the Wellington procedure. Women opting for home births are not booked in, but midwives have the same contracts as GPs, so in case of transfer, women are admitted without any problem and the midwife continues with her care. This process was worked out by consultation between hospital staff, DMs, GPs and consumers. In Auckland it was a unilateral decision initiated by the NWH bureaucracy with the Board being manipulated into endorsing it on the basis of a complaint.

The meeting was assured that the team consultants are sympathetic to the home birth option. We find that difficult to believe after hearing about the consultant who stated at a meeting of health professionals, "Stuff women's choice". This despite the Cartwright Inquiry and official recognition that a woman's attitudes and values as well as those of health professionals must be carefully considered when decisions are being made.

If this is relevant in general, it is even more so in a teaching hospital. A 15-year analysis of c/section rates in an English teaching hospital found that emergency c/sections for fetal distress had made a major contribution to the increase in these rates. A retrospective audit indicated that 30% of the c/sections were unnecessary; that there was significant disagreement between auditors; and when faced with identical information at a different time, the auditors were inconsistent in 25% of cases. (Lancet v 336, no 8714, 1 Sept 1990, pp 549-551) As one social scientist says: "Many obstetric procedures masquerade as science, but are in fact ritual responses to a technological society's fear of the natural processes on which it still depends for its continued existence. Hospital birth has resulted in a proliferation of rites more elaborate than any known to any "primitive" society, and in it the energy of birth is directed away from the mother and on to the medical personnel who attend her." (RE Davis-Floyd, Social Science & Medicine, v 31,no 2, 1990, pp 175-188).

Finally, the issue of midwives in the Board's employ doing DOMINO births was raised. Initially Nightingale denied that this was happening, but then admitted that staff midwives were allowed to attend to friends and family in their off duty time. However, AK HBA has documentation of three cases where women have phoned Nightingale about DOMINO arrangements and have been given the names of ex-St Helens midwives who would be prepared to do this.

J.D.

The WHO emphasises the importance of women being involved in all aspects of decision making in their care and recommends increasing "the role of women in defining their health needs, in planning their services, in evaluating their services, and in choosing the way in which they will use their services. Each women should have an informed choice concerning the application of the care to herself" (WHO 1985).

International authorities, in a major 10 year review of the world literature on the effects of care during pregnancy and childbirth, concluded that the failure to involve women in decisions about their care should be abandoned (Enkin et al 1989).