'Whose body is it? Whose baby is it?'

For women, childbirth is an intimate emotional event, the first step in a lifetime relationship between mother and child. For doctors, it is a medical event. This basic difference of attitude is at the heart of a major debate discussed here by staff writer Pauline Ray, whose own two experiences of childbirth have mirrored the two sides of the debate. Her first baby was a sedated forceps delivery and she hardly saw the child for 24 hours. The second time she was not sedated, did not have an episiotomy, and found it a memorable experience.

PATIENTS HAVE NEVER played an important part in making policy for hospital maternity care, but now they are starting to demand it—or to ignore the system altogether. A growing number of women are choosing to have babies at home, often because they prefer the intimacy of their own home, but also, negatively, because they cannot bear the thought of being a possible guinea pig in a large teaching hospital.

In Britain, consumer organisations like the National Childbirth Trust, the Patients' Association and the Association for Improvements in Maternity Services played a key role in the active debate which continues today. The debate gathered momentum after the release of a report by the Oxford Consumer Group in early 1974: this public opinion survey found more adverse comments about the maternity services than about any other branch of the National Health Service.

In the United States midwifery is illegal in many states and prison sentences may be served on people without formal obstetric qualifications who delivered women. This has in fact happened in California. Yet more and more American women are having babies at home, partly because of the high cost of medical treatment, but also because couples are questioning the quality of the emotional experience in many hospitals.

The British debate was sparked by the issue of induced labour, which in some hospitals was occurring in as many as 30 per cent of all births. "Daylight obstetrics" were promoted; it was argued, for instance, that as there were more of a hospital and laboratory staff on duty in the daytime, then it was safer for women to have babies during those hours. But although the press continued to concentrate on the issue of induced labour it was clear that the debate was really about more fundamental aspects of maternity care. Pregnant women were proving less and less willing to adopt the role of sick patient in which doctors throughout their training had been tacitly encouraged to see them.

From the point of view of obstetricians, the overriding concern has always been the potential for rapid and catastrophic departure from normality in childbirth. So, in order to control birth and make it safer, obstetrical science devised a routine series of interferences designed to "improve" upon natural birth. The 1970s were the era *par excellence* of technology in childbirth. Care during pregnancy was extended to include the assessment of foetal wellbeing by means of placental function tests. The early recognition of abnormalities in the foetus became possible. The pharmacological control of labour with oxytocin and prostaglandins increased the scope for inductions and the augmentation of labour.

Midwife Joan Donley on the job, applying acupuncture to relieve Lynda Jeffs's pain.

In most Western countries the induction rate increased, as did the rates of Caesareans (they doubled in the United States) and forceps deliveries. Episiotomy, an incision made in the woman's perineal tissue, became an almost routine procedure in many hospitals.

Suzanne Arms, author of *Immaculate Deception*, a radical look at childbirth in America, called it the "just in case" game. Just in case you haemorrhage, we'll give you simulated hormones before you expel the placenta; just in case you tear, we'll make a neat incision; just in case labour tires you out, we'll give you an early sedative. Another insidious "just in case", not mentioned by Arms, is: just in case you sue, we'll do a Caesarean wherever there is the slightest doubt, or use a foetal heart monitor as often as possible.

Technological interventions were often made with the best of intentions (ie, to make childbirth safer) but the contribution of these various changes to reduced perinatal (in the first week of life) and maternal mortality rates is not well-documented. There is no doubt that childbearing has never been safer for mothers and babies, and further improvements can be expected. The perinatal mortality rate in New Zealand is now about 14 for every 1000 births, compared with about 40 during the Depression. This has been attributed largely to scientific advance and the increasing hospitalisation of mothers. Many social changes, however, could also account for it. Women give birth at a safer age, they have smaller families, they are fitter, and they have better diets than their forbears.

Photographs: Robin Morrison

Seconds after a home birth, Auckland mother Lynda Jeffs cradles her baby, surrounded by friends and (left) midwife Joan Donley.

CHILDBEARING WOMEN do not necessarily knock technological change. What they are asking is to be more informed of the risks involved. Take episiotomies, which are used in 44 per cent of the births at National Women's Hospital in Auckland and which were used in 75 per cent of all hospital births in Dunedin in 1978, according to a survey of consumer satisfaction with maternity services in the area. Doctors defend episiotomies because of the terrible tears they have seen on women. But midwives working in the Auckland area use episiotomies in only 2.5 per cent of births, and say that less than 10 per cent of women tear — and then only slightly, requiring one or two stitches. They put their lower rate down to the encouragement of perineal exercise and to a slow and gentle head delivery. Women who have suffered the week-long shuffling walk of the post-episiotomy patient might well be prepared to take the slight risk.

The medical profession is undoubtedly susceptible to rumbles among its consumers. The Board of Health's maternity services committee has been surveying community maternity services, including home births and early discharges from hospital. In a policy statement entitled "Obstetrics and the Winds of Change" the committee observes:

"Nowhere do the winds of change blow more strongly than across the fields of obstetrics. We in the medical and nursing professions face a major challenge to meet the demands of a vocal minority, as well as the larger needs of the majority . . . Many of us have been trained to look after our patients within a rigid hospital framework. But this framework does not suit the young mothers of today.

"We must be prepared to replace rigidity with flexibility, if we are to keep our patients happy."

Another area where many women profoundly disagree with the medical profession is the trend towards fewer and larger hospitals. Undoubtedly this has been brought on by financial restraints and the falling birth-rate, but it is also Government policy that babies should be born in relatively few centralised units staffed by specialists providing a uniform service.

It is part of the "statistics" game; to catch the relatively few mothers at risk, all mothers need to go to hospital. According to American studies 70 per cent of birthing women, if given adequate prenatal care, could deliver their babies normally and without medical intervention, another 20 per cent may have complications that require prenatal care and some special attention but these mothers could also give birth normally, again without need of medical interference.

In recent years Auckland has seen the closure of East Coast Bays Hospital, the Mater and the Salvation Army's Bethany. GPs there face a restricted choice of beds to book their patients into.

In the Wellington region 12 small maternity units have closed since 1975 and a full-scale row has been going on over the forthcoming closure in June of the custom-built St Helen's in favour of the new $13 million O and G block at Wellington Hospital.

The decision to close St Helen's was made after two years of protracted debate by the Wellington Hospital Board. The board originally intended to operate St Helen's in conjunction with the new block, but it now says the falling birth-rate and population in the area have made this plan uneconomic.

Members of the vocal St Helen's Action Committee say the new block represents a reversal of the days when New Zealand led the world in the social aspects of obstetric care. By 1938 New Zealand was the first country in the Commonwealth to allow every woman to choose her own hospital, her own doctor, an anaesthetist and 14 days in hospital at Government expense.

Linda Saunders, of the action committee, believes there has been a lack of research into what women want. The women are against many features of the new block — the preponderance of four-bedded rooms (which makes rooming-in difficult); the windowed nurseries where fathers go back to peering at their babies; windowless labour rooms at basement level.

But mostly, the committee asks, what justification can there be for closing after only 12 years an institution which itself cost millions of dollars to build and equip and which was providing a satisfactory community service? (St Helen's is reportedly to be converted to geriatric facilities.) The women are unimpressed when doctors point out that the new block will have all the latest equipment and facilities. They point out that overseas the trend is to natural childbirth in smaller, less highly technological institutions.

Saunders: "We are going from a situation in a pleasant hospital, with facilities for birth and aftercare that women like, to a technological situation where you don't have your own doctor. They say it is an advance in obstetrical care. In 10 years thay will want to reopen St Helen's.

"St Helen's is away from the main hospital — only five minutes away. It doesn't have the connotations of hospital size or of illness. It was run by midwives, with no hierarchy. It was like the old-fashioned 'going into the home'. All the people there were healthy mothers."

Saunders believes that when the new block opens there will be a great rush for home births in the area. One domiciliary midwife is already working in Wellington and an incorporated society is planning to set up a birth centre in a house. Pam Skelton, a Wellington midwife who is a member of the society:

"We are emphasising the whole concept of choice. People are individuals the way they give birth. It is a health service run by the consumers. We are going to have full antenatal and postnatal services and counselling."

She cautions that although the group will give antenatal advice to all women, it will provide birth facilities only for women in the low-risk categories. She hopes the group will have a good working relationship with hospitals; it did not spring up in opposition to the new block she says, but has grown organically.

Nevertheless Skelton. who has been a hospital midwife for four years and has had two children of her own, believes that women won't get changes in hospitals unless they ask for them. She thinks health professionals don't tell women enough about birth.

"The only way the medical profession evaluates birth is by the neonatal and maternal mortality rates. One of the things we are going to do is evaluate the pyscho-social aspects . . . Hospitals can be made more like homes, but you have to ask where the priorities are. At big hospitals the priorities are teaching medical students, so they have to interfere.

"We will be providing a homelike atmosphere, a double bed, nice furnishings. People come in early in their labour, not in a last-minute rush during transition. They can bring their own families, live at the centre and cook their meals there."

ANOTHER INCREASINGLY popular alternative, particularly in the Auckland area, is home births. There are now five domiciliary midwives working in the Auckland area, doing more than 200 deliveries a year. The Home Birth Association defines a proper home birth as one planned by the parents months in advance of the due date, in which the importance for the mother of good diet and health in the antenatal period is heavily emphasised, the father frequently plays a crucial pyschological role during labour, and a domiciliary midwife and doctor are always in attendance. The association believes about 75 per cent of pregnant women are eligible for such a birth, but women at risk include those with a gestation age of less than 38 weeks; older women; women who have had previous Caesareans; and women with bad obstetric histories.

Joan Donley and Carolyn Young are two of the Auckland midwives. They are both booked up to the end of the year. Both were once hospital midwives but they have been practising as domiciliary midwives since 1975.The Department of Health pays them $25 a delivery (even if it is a 24-hour labour) and $5 for each of 14 postnatal visits. They get travel allowances which have not been updated to keep pace with petrol price rises. They both earn minimal incomes compared with, say, Plunket nurses, who make between $10,000 and $12,000 a year.

Donley, who is Canadian-born, has had five children of her own and delivered two of her grandchildren. She talks about the "politics of childbirth".

"What we are really talking about is: in whose interests is the present institutionalised method of childbirth in New Zealand? . . . One thing is for sure, the power is not in the hands of the woman having the baby. She has to fight every inch of the way to have a choice of alternatives. If she goes to hospital she has to fight to resist sedation, induction, foetal heart monitoring, oxytocins, separation from her infant and husband. If she decides to

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have her babe at home she has to resist social pressure and intimidation, even unprincipled scare tactics. Nobody seems to ask: 'Whose body is it?' and 'Whose baby is it?' "

Donley doesn't recommend home birth for all women, "but it is for girls who have accepted responsibility for their own health".

Young said it took her some time to shake off her hospital background once she started attending home births.

"I had worked in hospitals for a number of years. I was becoming disillusioned with what was going on in hospitals, even though I had no knowledge what an alternative could be. I felt women were brutally mishandled by nursing staff and I saw crassly ignorant treatment by doctors. Even though I was in the system I could look at it and be appalled. I had accepted that most women after they had delivered were like women who had been hauled in from the sea after being shipwrecked."

Young arranged to go with Donley to observe her first home birth.

"It was all so low-key and normal. I came away and couldn't get over it. I thought — 'What on earth are we doing wrong?' It was an entirely different phenomenon to what I had ever seen. That's when I started thinking this was what I wanted to do, but I started off with very hospital thinking. My first patient cleared me of a lot of hang-ups of sterility. She put her teacup on my instrument table in the middle of a contraction. It threw me completely — but she didn't die of the plague. I went out for a while with Joan. We both had the fear indoctrination from hospitals so strongly.

Home birth midwives Carolyn Young (left) and Joan Donley: "We both had the fear indoctrination from hospitals so strongly."

"There is a standard rule that if a woman hasn't delivered within a certain time limit she automatically has a forceps delivery. After some time standing with a woman going beautifully we had reached that point and I thought, 'What now? She has had that hour' — and it suddenly occurred to me to say, 'Who has the right to say women should be delivered within an hour?' . . . They don't [in hospitals] see the person as an individual. They keep thinking these things are man-made, made by men who haven't had babies or who don't know what a normal birth is."

Young has two adopted sons but eight months ago at the age of 34 gave birth to her first baby at home. She was delivered by Donley, and says she "learnt a lot".

"I felt the labour was enough to cope with without anything extra, without a hospital environment and actually being hassled. It was good to hand over my care and concentrate on what was happening to me." One of the chief reasons Young chose a home birth was that she feels it is easier that way to establish the mother-and-child bond. Both Donley and Young feel it is easier to establish feeding in the relaxed comfort of one's own home.

Pyschology lecturer Deryn Cooper had her baby at home two years ago, against all advice from colleagues, medical and otherwise.

"I knew I was not a suitable patient for hospital," she says now. "I'm not good at receiving orders."

At first, intending to have the baby in hospital, she asked her obstetrician if she could give birth upright, and also if she could be the one to determine whether she needed drugs or not. Her doctor acceded to the first request but not to the second.

"He said that because I was there I would not be able to tell when I needed them, and that injections needed a period to work."

So Cooper and her husband, Geoff Bridgman, a psychologist with the Intellectually Handicapped Society, started looking " for a good place to give birth".

"We heard of a midwife [Donley] and went to see her. Unlike doctors she was keen for us to grill her. She was most forthcoming and seemed to us to have more knowledge."

Cooper, at 32, like Young, was an "aged primagravidae". She had a long labour, 24 hours, without sedation, and her child was 10 pounds.

"It was a fighteningly personal experience. You are bared to the very soul. I liked the freedom at home. I could walk around, splash water on myself, hang onto Geoff. How women survive in hospital I do not know. You are made more vulnerable, therefore you are a patient. Utterly dependent. At home you are vulnerable, but not dependent. The relationship between parents and mid-

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'Safety first' in hospital

Pauline Ray talks to a childbirth expert who says he personally wouldn't like to see a relative of his delivered in anything other than a hospital with full facilities.

Dennis Bonham: "What do you want out of technology?"

PROFESSOR Dennis Bonham, head of obstetrics and gynaecology at the postgraduate school at National Women's Hospital, Auckland — where more than 4000 babies are born every year — does not give the home birth movement a high "research priority".

"We have heard home birth people say they haven't had a death in 100 or so cases," he says "but it would take 20 years to find out anything worthwhile, because there are so few home births. They represent only about half a per cent of all births in New Zealand.

"It is a growing trend because it is being stimulated. There are a group of people who are interested in it, who are fed propaganda from other countries. If I had to develop research and ideas I wouldn't give it a high priority. My first job is to see that everyone in New Zealand gets safe obstetrics. The second thing is good human relations."

Is hospital the best place to have a baby?

"If you want to minimise the risks to the life of the mother and child, yes, and the sort of hospital you have it in has to be a reasonably developed hospital. I think more people (in the future) will be delivered at base hospitals."

Bonham reckons that only a small proportion of women — "let's say 25 per cent" — are suitable for home birth or for a small hospital. He says maternity hospitals have passed through the high-technology phase and are now concentrating more on building good human relationships. NWH has eight foetal heart monitors but he says the hospital monitors only patients "at risk".

"It is not necessary to monitor every baby with a machine. It is much nicer to have a midwife."

Caesarian sections represent 11 per cent of births at the hospital, labour is induced for less than 20 per cent of births — "and remember, we are a grossly abnormal hospital" — and the episiotomy rate is 44 per cent (Bonham maintains the operation has a fair relationship to subsequent sexual satisfaction). Most women have sedation "because they ask for it" but Bonham denies that pethidine slows down labour:

"It has virtually no side-effects apart from the fact that the person becomes disorientated. That is a problem, but it is the best drug we have at the moment."

One of the main complaints women have about the hospital is that they are delivered by duty doctors, not by the doctor or doctors who have been attending them throughout the pregnancy. Bonham replies:

"It is complicated because pregnancy takes a long time and a lot of our residents change every few months. We have a system which we are developing where we are trying to deliver the patient as closely as possible to someone they know."

He says there have been some positive developments over the past 16 years at National Women's.

"It started 16 years ago when husbands started coming in. We cut out shaving and we experimented with suppositories, and we found a very small chemical enema, the equivalent more of a suppository.

"We let any old friend sit with a patient (in labour), although not six friends. We have encouraged people (in labour) to stay on their feet, but we haven't enough day-room space, so that is a problem.

"The majority of our women have their babies (rooming) in with them. If the baby is sick and has to go into the special care unit the mother has a Polaroid photo of the baby."

Bonham says that all studies done have shown that women want to be informed about labour and childbirth, but he says a fair number also want their doctors to take full responsibility for their care.

"This 'patient' thing is a spinoff from feminism, not wanting women to be branded as 'patients'. Of course childbirth is a normal procedure, but let's really get down to it and say it was normal several hundred years ago for many people to die before the menopause. Where do you draw the line? What do you want out of technology? Do you accept a perinatal death rate of 100 per 1000, which is what it used to be?" ●

Lynda Jeffs after her home birth: choosing to have the baby her way.

wife has to be equal. That is not possible in a hospital environment.

"One thing I would push is that the psychology of birth has to be the most powerful factor when all predictions are that it would be a normal birth."

THE HOME BIRTH Association was formed in Auckland in May 1978, basically to support the practising midwives and also to do research into the subject. Lawyer Barbara MacFarlane, who has had two home births, is the president.

Despite frequent statements by the medical prefession that home birth is not safe, the Auckland midwives have delivered more than 500 babies in five years with a loss of only two, one of whom had encephalitis.

The association points to the experience of the Netherlands, for nowhere in the Western world is there such a big percentage of births that still take place in the home (47 per cent in 1975). Since the beginning of the century a two-team approach has been taken to midwifery there: one team dealing with pathological obstetrics in hospitals (doctors and nurses) and another dealing with normal straightforward labours (a midwife with three years' training plus an assistant with 15 months' training). The perinatal mortality rate for the 85,000 Dutch home births in 1974 was only 4.2 per 1000.

Holland is of course geographically suited to such a system, for women are usually only minutes away from a base hospital. Nevertheless Professor G. Kloosterman, professor of obstetrics and gynaecology at the University of Amsterdam, and an advocate of home birth, believes that frequent clinical checks during pregnancy are more important than "sophisticated technology". He believes that 70 per cent of first births and 90 per cent of subsequent births can happen at home or in a very homelike environment, such as a birth centre.

Geoff Bridgeman, a member of the committee of the Home Birth Association's Auckland branch, says there is a lot of pressure to stop home deliveries in New Zealand. The one obstetrician in Auckland who would attend home births has said he is no longer able to do so because of pressure from his colleagues.

Bridgeman also reckons that hospitals will not really move away from their technological attitude towards birth.

"There are too many vested interests in it. It's really mixed up with the push you get from the business behind medicine, not capitalism, but if you are doing research on new equipment or new drugs you are not going to make your name by showing you don't need the stuff.

"You can't evaluate a foetal monitor until you evaluate all sorts of things that go with the foetal monitor, like being tied down. The whole area of evaluation is so full of pitfalls, so they just go ahead and use it, because it is a nice toy. It keeps the profession in a secure position because only a certain amount of people are allowed to use it. It reinforces institutional routines. Rather than observing the woman you are observing the machine."

MacFarlane says she sees home birth as "an option". She says many people have happy births in hospital and she doesn't want to knock that, but she remembers "great joy" in her street during her births.

"My mother was there. My sister was there. My husband took his annual holidays. It was a family event. I liked being able to move around my house. I didn't move upstairs until the middle of transition. I lay down and half an hour later had the baby."

"I think the satisfaction comes from being with the patient for the whole labour. Doctors are in authority positions. Midwives are in support positions."

She regrets that birth and death have been removed from our community. Most people in earlier centuries witnessed birth and were involved in breastfeeding.

"We all lose by that: 95 per cent of obstetrics is folklore.

"It's very much a woman's thing. But we are no longer confident in ourselves and giving birth should be one of the things we are most confident about."