Leading home birth country studied

As model or oddity Holland stands out

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An independent midwifery profession is the key to the Dutch system. It is supported by the Government, with protection, such as a decree in 1941, that women covered by the national health service get a midwife's services free — provided a midwife is working in her area. Her own family doctor is not paid for obstetric care.

There are also built-in backups, such as maternity aid nurses who help in home deliveries and after care in the home. This means new mothers can have help at home in the early days following the birth.

A complex list of selection criteria rates Dutch women's pregnancies as either normal (physiological) or having complications (pathological).

Under this revised system midwives are gaining more control over birth. They have the initial responsibility of deciding who comes into which criteria.

For women this means sometimes having to deliver in hospital under the care of an obstetrician. Sometimes if there are less serious complications, the midwife does the delivery — but it has to be at a hospital.

But for women with normal pregnancies there is a free choice whether they give birth at home or in hospital where their midwife can work independently — though the ability to choose is sometimes complicated by added costs for hospital births.

Of all births about 42 per cent are attended by midwives, 42 per cent by obstetricians and only 16 per cent by family doctors. For home births up to 60 per cent are attended by a midwife.

About 50 per cent of women start out their pregnancies opting for a home birth and midwife. Of these, complications or choice land some in hospital, leaving 35 per cent having home births.

At times a fierce debate rages between midwives and obstetricians — each trying to hold onto their positions in the ring.

It has also produced some other side effects — a low rate of caesareans, around 6 per cent compared with a soaring 25 to 30 per cent in the United States, and what a leading Dutch obstetrician calls a very low use of pain relievers in labour with about 5 per cent of deliveries.

One of the hot topics of debate is Holland's perinatal death rate. This is a widely used indicator of the outcome of pregnancy and childbirth and standards of care.

Holland leads with the world's lowest perinatal death rate for 25 years, some obstetricians are keen to point out. Now it has lagged behind, but the rate continued to drop from 13.9 per 1000 in 1975

healthline

As winner of the 1989 Researched Medicines Industry Travelling Fellowship Nelson Mail health reporter JULIE SMITH (pictured right) visited Holland which has a unique system of obstetric care that attracts worldwide interest.

In this special healthline she reports on its home birth practice and talks to midwives and obstetricians there plus updates the New Zealand situation on home births.

Midwives lobby for NZ law change

A law change is currently under review in New Zealand which would enable midwives to practice independently.

President of the New Zealand College of Midwives, Ms Karen Guilliland, says the organisation is lobbying in favour of the law change.

At present the Nurses Act requires a doctor to take the final responsibility for deliveries.

In early November last year an amendment went through a first reading in Parliament removing the requirement for a doctor to take responsibility.

It is now being considered by the Social Services select committee with submissions closing on February 9.

Ms Guilliland says midwives are also trying to get a direct-entry three-year course in midwifery set up.

Irrelevant parts of nursing training would then be left out of a midwife's training.

Presently, midwives attend a one-year post-graduate course after qualifying as registered nurses.

Spokeswoman for the Nelson region of the college, Mrs Angela Kennedy, says a submission supporting the law change had gone forward from the Nelson members.

If the law change goes ahead it would have a more immediate effect on domiciliary than hospital midwives.

Spokeswoman for the New Zealand Domiciliary Midwives Society, Ms Bronwen Pelvin of Nelson, says some of women to make choices about the obstetric care they wanted.

Developing a system that gives better continuity of care is also important. He says it might take years to develop a new system.

The present system is fragmented because women are cared for by a range of people in hospital and after discharge, he says.

The law change could clear the way for women to choose to take out contracts with midwives who could provide pre-natal, delivery and post-natal services.

Opposition to the law change is being shown by some general practitioner groups, who are also using the argument for continuity of care.

One submission endorsed by the Auckland Faculty of the Royal New Zealand College of General Practitioners was published in a November issue of the New Zealand Doctor newspaper.

It said if midwives were allowed to carry out obstetric nursing without a doctor taking responsibility, it breached continuity of care and meant the patient had no one to turn to in an emergency other than the midwife she chose.

"We suspect few midwives would relish this responsibility but some may accept it, with possible dire consequences for mother and-or child."

It went on to quote a midwife's submission which said GPs should be available as a back-up and consultant for midwives when childbearing

Emphasising home birth as normal and healthy event

SO MANY Dutch babies being born at home means women can see pregnancy and childbirth not as illnessess but as normal events, says a Dutch professor in obstetrics and gynaecology.

Professor Pieter Treffers, head of obstetrics at a major Amsterdam Hospital, the Academical Medical Centre, says if hospitals are the only birthplaces an unhealthy impression is created. Birth is seen as something like an operation.

He is an influential figure in Dutch medicine as his department is part of the University of Amsterdam and medical students are trained at the hospital.

Here they work alongside midwives. In some medical training hospitals in Holland midwives are absent.

The full range of births from normal to the most difficult are dealt with. Medical students can also volunteer to spend time working with an independent community midwife at the end of training, so seeing home births.

The professor is a striking character. He comes across as remarkable for his ability to objective open criticism of his own profession, along with midwives.

"It may be important that normal pregnancies are under the care of a profession not entitled to interfere in normal pregnancy and normal labour because in the whole world the number of interventions is increasing," he says.

He cites Holland's low rate of caesareans and low use of pain relievers during labour as due to the influence of midwives and women's views of labour.

In a paper published in 1986 in the journal Hormones and Behaviour, Dr Treffers graphically describes a serious mistake he made in a foreceps delivery of a baby.

He goes on to challenge doctors to openly admit making mistakes.

"It is difficult, after having failed, to go back to the patient and to discuss it openly. Nevertheless, that is what the patient usually needs

children despite all the interventions by the obstetrician..."

Dr Treffers says the medical specialists should also keep a critical eye on midwives and vice versa.

Obstetricians have to point out that problems should be recognised in time, and midwives remind them that sometimes more investigation and intervention is done than necessary.

A criticism of the Dutch system comes from obstetrician Dr Frans Roumen, who works at one of Holland's three training hospitals for midwives — the St Elisabeth Clinic in Heerlen.

He says midwives select normal pregnancies and refer on pathological ones but there is no requirement to monitor standards or give feedback.

"If there are problems with the delivery, the midwife may not tell anybody. No one has to check.

"Of course we think all of the midwives try to do their job as best they can but there is a problem in this system because everybody wants to have a good result — obstetricians, midwives, paediatricians, parents — and when the results are not as good as you want them to be you can do two things, talk about it or not talk about it."

For midwives working alone it is easier to fudge the results, he says.

But a midwife tutor at the clinic, Margot Elinys, says more and more midwifery graduates are working in group practices. About 8 per cent work solo.

She says there is feedback from colleagues. Obstetricians are in the same position at deliveries — with only assistants present.

Dr Roumens also cites doubts that all midwives bring babies with low birth weights into hospitals for checks, that midwives underestimate blood loss during labour and that perinatal mortality rates are underestimated in Holland because both obstetricians and midwives do not always record them if parents want to avoid the expense of burying their baby.

Ms Elinys says: "Whatever it is there will always be people who

archy — a threat to the independence and strength of midwifery."

In a region of eastern Holland, Deventer, work of independent midwives in the community has been integrated more closely with the hospital system to attempt to overcome some of the communication problems.

Here complicated cases can be discussed by a team involving midwives or general practitioners and obstetricians.

When midwives or GPs do hospital deliveries they work as registered hospital staff members. Regular meetings take place to air problems.

There are about 155,000 people in the region. The city of Deventer is becoming industrial and has attracted workers from Turkey, Morocco, Spain and Italy. In the city about 50 per cent of deliveries are at home.

In the surrounding rural area between 50 and 80 per cent of deliveries are at home.

Deventer obstetrician Dr Jaap Schierbeek says: "In this region obstetricians and midwives get on well, but there are also regions where they don't talk to each other.

"When there is bad communication there is always trouble."

The Deventer team talks of problems in other areas and also in their own region of fierce competition between midwives and GPs.

Obstetrician Dr Bram Donkers says in some areas hospital specialists feel their hospitals become a "large dustbin" of problems when complicated deliveries are brought in at the last minute.

But Deventer midwife Ms Therese Hoorn says: "Because there is good communication (in Deventer) between midwives and doctors not many cases are sent at the last minute."

Different attitudes between mid-

from 13.9 per 1000 in 1975 to 10.0 in 1982.

One of the points of debate is over the reliability of perinatal mortality statistics; whether a newborn baby dies or is stillborn is not always recorded.

Comments by obstetrician Dr Frans Rounen of the St Elisabeth Clinic, a training hospital for midwives, in Heerlen, reflect the concern of some obstetricians. He sees the system as something of an experiment.

He does not blame home birth for the perinatal mortality rate, but calls for better standards for registration of births.

"I think we can be very happy to live in this special country where there are very good social environments so we can have an experiment of this kind.

"It would be impossible in Spain, France or Sweden. Distances between home and hospital are far too great.

"In Holland it's always possible to be in hospital within 15 minutes, so when there are real problems you can come to the hospital."

Domiciliary Midwives Society, Ms Bronwen Pelvin of Nelson, says some women in the Nelson region have problems getting a doctor to support their plans for home births.

In Motueka no doctors are prepared to attend or take responsibility for them.

Ms Pelvin publicly admits having attended a home birth 1988 without a doctor taking responsibility.

She says the law change would relive the situation for women wanting home births and also meant midwives would be able to give more complete care.

A member of the Nelson branch of the Home Birth Association, Mr Nigel Costley, sees the law change as a first step.

The home birth versus hospital birth argument is secondary, he says.

The most important issue is the right

mission which said GPs should be available as a back-up and consultant for midwives when childbearing deviated from normal, physically or mentally.

GPs knew the families and were valued colleagues. Working together midwives and GPs could provide a very high quality of care and comprehensive follow-up.

In New Zealand in 1988 there were 515 home deliveries, according to the National Health Statistics Centre.

Another 77 were classified as not planned and for 24 it was not stated if the home birth was planned or unplanned.

Including these deliveries makes a total of 616 at home, while there were 55,771 hospital deliveries, meaning home deliveries made up a little over 1 per cent of births.

to go back to the patient and to discuss it openly. Nevertheless, that is what the patient usually needs most and, truly, what the doctor needs himself."

In obstetrics Dr Treffers says both midwives and obstetricians have confidence in their management of deliveries.

This attitude will not do too much harm if they stick to selected patients — low-risk pregnancies for midwives and high-risk for obstetricians.

Obstetricians who are not critical of themselves are in danger of performing more and more unnecessary interventions, says Dr Treffers.

"The uncritical obstetrician will be convinced his therapy is effective because normal pregnancies usually end in normal deliveries of healthy

them if parents want to avoid the expense of burying their baby.

Ms Elinys says: "Whatever it is there will always be people who work with the rules and try to do a good job ... and you always have a group who do not.

"I do know that obstetricians see just our mistakes and that gives them the wrong impression of our work."

But Dr Roumens says mistakes are not the problem. It is when midwives are conscious of mistakes but put them aside which concerns him.

This was a point Dr Treffers made about doctors themselves. His 1986 paper noted medical literature was biased against reporting failures and complications. Only positive results tended to be written up for publishing, he said.

"Several years ago we published a paper about complications of early amniocentesis. We have met severe and open criticism — complications like these could only occur with inferior techniques used by bad doctors."

Dr Treffers says checks on performacne were needed for all, midwives and obstetricians.

He favours compulsory national registration of births. It has been done voluntarily, with obstetricians registering 70 to 80 per cent of their deliveries and midwives a higher percentage.

Emphasis on problem solving, communication and constructive criticism are the basis for midwifery training at the St Elisabeth Clinic, says Ms Elinys.

A new system of training began with changes to the way problem pregnancies are selected by midwives.

Dutch midwifery training is aimed at preparing the midwives for independent practice.

There is competition for places in the three-year course and it is very hard for nurses to get admitted.

Midwife campaigner Ms Astrid Limburg comments: "Women who train as nurses have learnt to become a part of the hospital hier-

many cases are sent at the last minute."

Different attitudes between midwife and obstetrician are still apparent here.

Ms Hoorn says: "Sometimes it's easier for us to go to the hospital for deliveries, but it's more cosy to do it at home. I like it more at home, but in hospital I admit it's easier for the midwife."

Dr Schierbeek says: "I see hospital as safer. I wouldn't be comfortable to do a delivery at home in a strange room."

Across cultures and regions in Holland variations in the home birth rate are evident.

In Deventer the older generation of Turkish immigrants preferred home deliveries but younger women now see this as old-fashioned.

In rural communities home birth has tended to hold out more strongly.

In Amsterdam Dr Treffers reports a new trend.

He says research has found a major difference between women preferring home and hospital births in Amsterdam.

Those choosing home births were older, more educated with better paid jobs and more status in society.

These more educated, independent women are also preferring to have vertical deliveries more often.

Vertical deliveries were introduced to Amsterdam by midwife campaigner Ms Limburg.

Dr Treffers says women choosing to deliver babies in his hospital were often immigrants. They came from Africa, Pakistan, India and Indonesia.

"These people like to deliver in hospital because in their own country delivery at home is something only the poor do."

Linking natural safe birth to women's independence

NATURAL safe birth goes hand in hand with autonomy and independence for women, says Astrid Limburg.

She is one of the new generation of Dutch midwives. In partnership with two other midwives her independent practice attracted about 350 clients last year.

She is a militant fighter for the midwives' role and works closely with prominent midwife Beatrys Smulders, vice-president of the Dutch midwives association (the Netherlands Association for Wise Women).

Through her practice about 90 per cent opt for home birth.

"A woman has to give birth where she feels safe, whether at home or in the hospital, because there she delivers best."

Limburg says: "The Government says if you are healthy it's very responsible and safe to deliver at home.

"If you want to deliver in hospital that is a choice but then you have to pay for the hospital room.

"I think this is a hideen persuader to give women self-confidence."

Within Limburg's practice the three midwives work a duty roster and every client sees each midwife.

In some joint practices the clients have their own individual midwife.

Limburg says in her practice the midwives are trying to make women self-confident and independent.

"Some clients ask if we will be on call when they are giving birth.

"We never say we will try to be there because that is making yourself too important.

"She has to know that she is doing the birth and that she can do it."

Limburg says there is an advantage in Holland where giving birth at home is an accepted option.

"Giving birth at home is a national asset and it's never gone away. It went down during the 1970s but never completely vanished."

Limburg describes the Dutch as having a "healthy doubt in medical omnipotence".

She tries to get across to women that a successful birth is not necessarily one without complication. But being in charge of the birth is important.

"You were in charge, you were doing the birth. It might have been an artificial birth with an obstetrician, but it's fantastic to see a woman working with an obstetrician — not having it done for her.

"She feels the same as a woman who has a natural birth because the baby wasn't pulled out of her — she pushed with the obstetrician."

She believes the Dutch midwife has been able to hold onto her position because obstetricians have always had to recognise her as an independent practitioner.

"Here in Holland, in a way, we are complementary."

There are midwives and maternity aid nurses working with women having normal pregnancies and births, and obstetricians and hospital staff working with women with complications.

Beatrys Smulders says the influence of midwives has meant hospitals have had to adapt their approach to women giving birth.

"The obstetricians have been influenced to meet the particular wishes of women in labour, and the result is that the doctors in Holland intervene less."

For Smulders and Limburg the fight ahead is to ensure home birth retains a place in Dutch obstetrics.

What is wrong with hospital births?

Smulders says: "For women, it means that they are always, and often unnecessarily, submitted to standard procedures.

"However flexible and open-minded the hospitals present themselves, invariably the woman in labour is turned into a patient and she loses autonomy, independence, self-confidence and strength — in short, qualities which are vital for effective contractions and, ultimately, for a successful, uncomplicated and safe birth. She unnecessarily becomes a risk."

Retaining home birth is the key to midwives wanting to maintain their independent status.

Smulders says if home births are prohibited, most midwives will lose their independence. With that would go specific skills, their reliance on nature and the capacity to differentiate high-risk from low-risk situations.

Midwives would be downgraded to obstetricians' handmaids.

She says most Dutch midwives work very long hours, for too little.

Little time is left to evaluate their work, to do research or contribute to the union of midwives.

This has led to some worrying trends for those pushing to maintain the independence of the profession.

Limburg says midwives are warned not to opt to do too many hospital births.

A midwife on duty in the weekend and wanting some free time might more easily refer a woman in labour to an obstetrician.

Some midwives refuse to do home births because they are more time consuming.

Limburg says hospital deliveries are easier for the midwife. All the equipment and materials are on hand and the midwife has the hospital back-up and therefore less responsibility.

The Dutch system has attracted a lot of interest from foreign midwives and obstetricians.

Limburg says the breakdown of European borders has encouraged many midwives to seek work in Holland.

As a member of the Commission for Foreign Midwives she is one of those debating the issues this raises.

She says the foreign midwives are not trained in selecting out physiological and pathological pregnancies — the essence of the Dutch system.

"Midwives are concerned there will be accidents and these midwives will not have the confidence to work at home — which is what the obstetricians would like — midwives at hospitals as handmaidens."

However, the foreign interest has also encouraged the Dutch home birth movement.

Smulders told a London midwifery conference in 1987: "We felt that everywhere in the Western world people were working very hard to get home birth accepted in their society again. This support has been an inspiration for our survival."

Anti-clotting snake venom

Two purified venom components from a dangerous Australian snake, the King Brown or Mulga snake, may soon be used to treat thrombosis and diseases involving blood clotting.

University of Queensland medical researchers Mr Paul Masci and Dr Alan Whitaker, and Melbourne biochemist Mr Frank Madaras, have isolated two molecules in the snake's venom which prevent thrombosis or blood clotting.

Thrombosis is a complication in many pathological situations including operations, cancer and a variety of vascular diseases.

It can be potentially deadly if clots in veins break off and travel to the lungs.

Clots can also permanently damage veins, resulting in chronic swelling of the legs or ulcers, which can cause strokes, heart attacks and other problems.

Mr Masci said the idea of using snake venom to treat clots was not as strange as it seemed.

"Purified proteins from one of the American rattlesnakes and generally in vipers (specifically the Malayan pit viper) have been investigated as agents to treat diseases involving blood clotting," he said.

"However, ours is a totally different substance, not previously studied, because we aim to stop clotting using these venom components by inhibiting the enzymes in the early stage of clotting."

The five-year snake venom research project followed from an 1898 observation by an Australian doctor that blood sometimes would not clot in people bitten by King Brown snakes.

With other confirmations of the venom's anti-clotting properties investigations revealed two anticoagulants, present making up about 40 per cent of the venom.

Isolated, the two proteins in the same manner as [illegible] aguants used in thrombosis treatment.