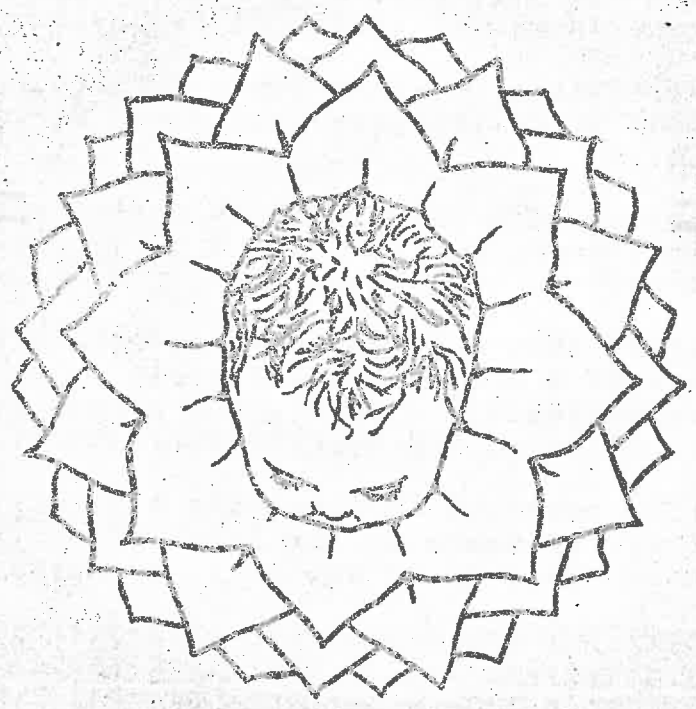
The New Zealand Home Birth Association

NATIONAL NEWSLETTER

No. 7
November 1982



CONTENTS

INCREASE IN PAY FOR DOMICILIARY MIDWIVES.

On Friday, 16 July, the Minister of Health, Mr. Aussie Malcolm, informed Lynne MacLean that he had secured a 17% increase in the pay of Domiciliary Midwives, effecitve from the 1 October, 1982. Because of the wage and prices freeze, however, midwives won't notice the increase until the f reeze has been lifted.

This increase brings the pay up to $ 165.55 per delivery, and this includes the one antenatal visit and 14 days' postnatal care.

Assuming that a comfortable workload for a domiciliary midwife in one year is around 50 deliveries, this gives her a yearly income of $ 8277.50.

A hospital staff nurse, with her midwifery certificate, earns $13,411 in her first year, and can earn $ 16,411 at the top of the scale (after 4 years).

It is a fait accomplit that a domiciliary midwife's work is at least the equivalent of a hospital staff nurse's, and definitely entails greater responsibility, strain , and stress in terms of non-regular hours, holidays, and unpredictability of work load.

The NZNA must therefore continue to press for a realistic increas e in pay for domiciliary midwives to the level of an obstetric unit staff nurse, at least. This means another % increase soon.

We are not ungrateful for the Minister's effort to improve the pay of domiciliary midwives, but in the light of his comment that he personally believes in a 100% hospital birth occurrence, the 17% increase can be regarded as a mere lollypop to keep us quiet for a while.

REPORT OF MEETING HELD BETWEEN LYNNE MACLEAN (Wgtn. Dom. Midwife) AND THE MINISTER OF HEALTH, MR. MALCOLM, on 16 July, 1982.

(N.B. I attended this meeting as witness and note-taker for Lynne).

The Minister asked Lynne what she wished to discuss, which was:

- Domiciliary Midwives' fees
- The implications of Dom. Midwives coming under the Hospital Boards.
- The NZNA's and other recommendations made to the Maternity Services' Committee. (We had recently been given a copy of the Committee's report from our National Secretary who had received it from a local M.P.).

The Minister immediately informed us that he had achieved a 17% increase in D.M's fees, effective from 1st. October, 1982. Because of the wages and prices freeze, this would not actually come into effect until the freeze has been lifted. We told the Minister that we were pleased , but that this still would not bring a D.M's fees upto the level of a hospital midwife, and that therefore wage negotiations would have to be continued.

Lynne asked him about the need to clarify the "annual review" of D.MS' fees, because she has never been able to find out when it occurs and how the process works. The Minister agreed that it

was probably a haphazzard and unstisfactory way of securing a wage rise, and recommended that midwives might like to consider using a recognised negotiating body such as the NZ Nurses' Assn. as a negotiating medium, although it was upto them to decide.

Lynne replied that the NZNA had indicated to the Dom. Midwives' Society that they would only negotiate on their behalf if they came under the control of the Hospital Boards. Lynne stated clearly that DMs wished to remain under the direction of the Helath Dept..

The Minister then said that he could not speak on this issue because he had not seen this recommendation formally, and had indeed still not received a copy of the Maternity Services Committee Report. He expressed surprise that we had a copy and that a number of parliamentarians had also seen it. He questioned Mr. John Phillips (Director, Clinical Services, Dept. Health) who was present throughout the interview, about this, and he assured that the report would be ready for him in a week. The Minister then said that it could take upto two months from the time he recei ved it to the time it was released to the public by the Government Printers.He felt that since the HDA and the DMs had already seen it, he would try to hurry the printers so as to release the report as quickly as possible to all who were interested in it, because the situation of some groups knowing the content before others was undesirable and unfair. He said thathe could release the rport to us before it was printed, but didn't went to do this. He will instead send the final report to Lynne for her to check that the content was the same as the draft report we have now in hand. This is so we can be sure we aren't developing arguments on recommendations which are not in the final report. This copy, he said, would be confidential and should not be publicised. He asked Lynne to supply him with the DMs Society's views on the recommendations in the report.

We then discussed how we saw some of the recommendations as undesirable and unnecessarily restrictive, that they would only serve to restrict the number of home births in NZ, and not 'improve' the service, as is claimed. We emphasised, that in any review of a DM's practice, it would be imperitave to have an unbiased review body, and that we need an assurance that the Minister would ensure this. He avoided giving us this assurance, and went on instead to talk about the emotionality surrounding the home birth issue and the importance of those involved in negotiations being unemotional. When we mentioned some of the difficul..ties being experienced with some new DMs in their relations with hospital and Health Dept. staff, he said that this conflict was not necessarily a bad thing. The 'tension' created led to changes in hospital practice, he said.

Mr. Malcolm said that he himself had no intention of imposing his views on others, but was entitled as an individual to have his own 'feelings and instincts'. He said he had no hysterical objection' to home births, but 'wished there weren't any'. His view is that many parents seeking a home birth do so for selfish reasons, i.e., because they do not like hospitals. He gathered this because of the content of the letters he received from home birth parents, which he said focussed on the advantages for the mother. He said "many who defend home birth do not consider the child".

We emphasised the need for objective scrutiny of the facts and figures of home birth in New Zealand as it has evolved over thelast six or so years as a basis for assessing the risks of home births- not overseas figures. We also pointed out that there were risks involved in having a babyin hospital too, which could be considered

to outweigh the infinitesimal increased risk in a home birth. He had no reply to this.

H. Kemp.

LATEST HOME BIRTH STATISTICS

We are very grateful to Bill Vant, of Hamilton, for computerising the statistics for the period 31 March 1981 to 31 March 1982.

Two hundred and fifty three (253) returns were received from 13 midwives (compared to 169 returns from 9 midwives the previous year). Since the total number of home births for that period was 461, the sample represents 55% of the total).

Variable			%, 1981	%,1982	Average
Para (Previous live births)	0		26	28	27
	1		41	36	38.5
	2		24	23	23.5
	3		7	9	8
Stable relationship			92	93	92
Smoker			5	7	6
Anti-D given			12	14	13
Iron tablets taken			19	23	21
Raspberry leaf taken			84	90	87 *
Antenatal preparation		none	27	34	30
		Parents'Centre	10	11	10
		HBA	13	36	24 *
		other	50	20	35 *
Maternal transfer to hospital(intra- and post-partum)			8	11	9.5
Pain-relieving drugs used			5	5	5
Acupuncture			19	20	19.5
Eclbolics			19	20	19.5
Blood loss:	less than 300 mls.		83	82	82.5
	300-600 mls.		15	15	15
	more than 600 mls.		2	3	2.5
Episiotomy			5	8	6.5
Sutured Laceration			27	28	27.5
Membranes ruptured spontaneously			74	72	73
Resuscitation needed (for baby)			4	4	4
Sex of baby		boys	50	50	50
		girls	50	50	50
Breast feeding established			99	99	99
Infant transfer			3	3	3
Hypertension during labour			2	2	2
Uterine dysfunction			3	1	2
Cord prolapse			0	0	0
Malpresentation			.6	1	.8
POP delivery			4	3	3.5
Shoulder dystocia			1	3	2
Retained placenta			3.6	.4	2
Mastitis			7	6	6.5
Other maternal infection			5	.8	3
Post natal depression			1	4	2.5
Accellerated labour			2	1	1.5
Forceps delivery (after transfer to hospital)			1	1.2	1
Caesarian section (" " " ")			1	1.2	1
Failure to progress			4	1.2	2.5
Foetal distress			2	3	2.5
Meconium staining			7	8	7.5

Statistics Cont'd.

Variable	% 1981	% 1982	Average
Dysmaturity	1	.8	.9
Foetal Abnormality	2	3	2.5
Birth Injury	1	2	1.5
Infection (infant)	9	12	10.5
Jaundice	32	28	30
Pleasure responses	43	34	38
Apgar Score, at 1 minute: 9 and 10	79	73	76 *
at 5 minutes: 9 and 10	98	97	97.5
Maternal transfer to hospital of mothers having their first baby (para 0)	16	26	21 *
Maternal transfer rate of mothers having subsequent babies	5	3.4	4.2
Average age of mothers	28 yrs.	27 yrs.	
Minimum age of mothers	20 "	19 "	
Maximum age of mothers	38 "	39 "	
Average lenght of first stage of labour	10 hrs	9.6 hrs.	9.8 h
second	1¼ hrs.	.9 hrs.	1.1 h
third	15 mins	12 mins	13 mi
Average birth weight of babies (at birth)	3,574 gms	3,454 gms	3514
Average discharge weight	3,854	3,856	3855

The rates of episiotomies and pain relieving drugs were again highest in the group of mothers having their first babies.

Mortality (perinatal) 0 2 out of 253.

---

* Significant differences in figures

* There was a significant difference in the percentage of mothers taking raspberry leaf tea, but no corresponding reduction in the rate of episiotomy, laceration.

* A signifiant increase in the number of home birth parents using HBA antenatal classes.

* Apgar scores of babies born at Birth Centre at Pithviers, France, (A centre where conditions are such as to create the most natural, instinctive birth experience possible) are quite low by comparison. At Pithviers: the average was 6.9 at 1 minute. Our average was 8 at 1 minute.

*An increase of 10% in the rate of maternal transfer of mothers having their first babies. This could mean that either an improvement in hospital-domiciliary midwife relationships, conducive to the midwife deciding more readily to transfer; or it could mean that midwives are taking on more cases whom they would perhaps have declined last year, because of an increase in confidence, perhaps. Of course the figures could be entirely arbitrary and bear no significance to anything.

NOTE Because the rate of return of statistical forms to our collator is only 55%, I think branches should perhaps be making more of an effort to ensure that their midwives are supplied with these and are filling them in and returning them.

HOME BIRTH ASSN. SPEAKS OUT ON IRRESPONSIBLE WATER BIRTHS

In July this year there was an article on the front page of the Wellington Evening Post about Wellington Women's Hospital being prepared to do a waterbirth. Some time later a small article followed saying that "Wellington's first waterbirth baby was born well upstream"- in Auckland, in someone's home, attended by Estelle Meyers from the Tutukaka Dolphin Centre and a midwife from Whangarei. Some days after that, there were headlines:"Appalled Mum saw daughter as a 'woman dying'. 'Appalled Mum ' was interviewed the next day on Radio NZ's Morning Report programme.
The Wellington Branch decided, after trying unsuccessfully to contact our national spokesperson , to make a statement to Radio NZ, to counteract the negative publicity this interview was generating about home births. Our statement was broadcast on the local news section of Midday Report, and expressed our concern at the unplanned and unprepared nature of this home birth and the damage its publicity was doing to our aim or gaining acceptibility for home births.

Our National Spokesperson, Marilyn Walker, followed up by sending letters to the eading NZ newspapers and to Estelle Meyers.
Lynne MacLean, secretary of the Domiciliary Midwives Society, wrote a letter expressing her concern to Isobel Smith, the midwife.

The waterbirth was obviously irresponsible because of the following factors:
- it is not at all clear that it was intended to be a home birth. On the face of it it looked as though the mother had arranged to have the baby at Wellington Women's. The house where the waterbirth took place was hurriedly arranged by EstelleMeyers and there was very little time to prepare the necessary things. The home was not the mother's home, and was more an 'out-of-hospital' birth than a home birth.

- the necessities for a safe waterbirth were not provided.They ran out of hot water, the tub was too small to be comfortable.

-The mother was shifted, at the grandmother's insistence, to a motel only a few hours after the birth, against the wishes of the midwife, who was aware of the danger of haemorrhage.

- Aquantance between the midwife and the family was not sufficient. Familiarity between the midwife and family, such asresults from antenatal visits and antenatal classes, is an important aspect ofresponsible home birth.Just as the midwife must be responsible, so must the parent.

- There was no doctor covering the birth. No midwife should attend a woman in these circumstances unless it is an emergency.

Isobel Smith is presently overseas in France (brushing up on water births) and Lynne Maclean's letter was replied by Estelle Meyers. Isoble Smith is now under scrutiny of the Nursing Council.

Estelle Meyers is now facing legal action over having an American midwife attend another waterbirth at the Centre, which again ended in the transfer to hospital due to the midwife not having the necessary suturing material. Apparently not one NZ doctor, nurse or midwife has registered for the International Conference on Waterbirths organised by her at Tutukaka.

MATERNITY SERVICES COMMITTEE REPORT

Our National Secretary, Nicky Conroy, received a copy of the draft reprt from a local MP. This copy contained all the recommendations made to the committee by the NZ Nurses' Assn.(these were circulated to branches), plus a few others. These were as follows.

1. Home aid services.
The committee recommended that home aid services be provided for mothers with young children who have chosen an early discharge from hospital, at a cost which is within their capability of meeting.

2. That the form H 678 filled in for all home births be photocopied and kept by the local hospital obstetric unit.

3. That the contract held by a domiciliary midwife should include the right to practice midwifery in a defined area only, (within a defined radius of the area's obstetric unit). The report reads "cases have been brought to our notice where the midwife has traveled many miles from her prime base of operations to deliver cases and this we think is undesirable".

4. That a domiciliary midwife should be able to practice in one hospital board area only.

5. That contracts to practise domiciliary midwifery be available only to registered midwives .(At the moment an obstetric nurse may practise domiciliary confinements ifthere is a medical practitioner present).

6. That provision for domiciliary midwives doing home births to undertake postnatal care only (i.e. do early discharges) be removed. (No reasons given).

7. That a contract should be able to be refused if a midwife applying hasn't had recent experience in a hospital. At the moment the regulations say that "the Medical Officer of Health cannot refuse an application for a contract if the nurse has the necessary qualifications and practising certificate. "

8. That provision be made for a paid visit on the day of birth, if the baby is born in the ealy part of the day. (At the moment the midwife is paid the lump sum for the birth and for subsequent visits on the following days.

9. That a G.P. doing home births should hold a current hospital board contract and should apply strict criteria for selction of home birth mothers.

10. The G.P. must be present at the birth.

11. That a midwife applying for a contract should have done two years' practice in a hospital immediately prior to practice and that she also receive training under supervision in a domiciliary situation.

12. That a contract ; be reviewed at the end of the first year of domiciliary practice and be reviewed after that at five yearly intervals.

13. That the number of domiciliary confinements done by a D.M. be 'preferably in excess of 15 a year'.

14. That domiciliary midwives have refresher experience in an 'approved' insitutmon for at least two weeks per year.

15. Sterile packs should be supplied by the hospital.

Although Mr. Malcolm had indicated that the final copy of thereport may differ from the draft copy we have in our possession, I think it would pay for branches to start preparing their ideas on these recommendations so they can be readily written up and sent to the Minister of Health and the Director of Clinical Services, Dr. John Philips, as soon as the final report is released to the public.

The following are significant excerpts from the report:

..." Home births in Hollandhave dropped from 71% in 1961, to 53% in 1973, and has continued to fall at the rate of 2% per annum..."

"In the UK, the drop in the percentage of home births has gone along ithe marked drop in infant and maternal mortality. This does not necessarily mean that one is the sole cause of the other. There are many reasons for the fall in mortality rate but those who have worked in the field of domiciliary midwifery over those years would assert that the increased rate of hospital confinement has been a major contributing factor..."

"... We do not believe that there will be any substantial increase in the incidence of domiciliary midwifery in NZ but it is probable that a small number of women will still choose this form of confinement. This being so, the committee believes that the highest standards of care should be promoted in this form of confinment and that people being delivered at home should be provided with the optimum back up services from the nearby obstetric unit..."

"..because of the unpredictable risks at birth, that cannot always be remediedby removal to hospital, the committee cannot recommend the practice of domiciliary midwifery..."

DOMICILIARY MIDWIVES MAKE SUBMISSIONS

The Domiciliary Midwives Society have received a copy of the Final Report of the Maternity Services Committee and were prompt to submit their ideas on its recommendations, accomanied with their own recommendations, to the Minister of Health and to the Director of Clinical Services.

Auckland's midwives have also been busy writing submissions in response to the Nurses' Assn's recommendations to the Committee and are duplicating these to be sent to all members of Parliament.

Do we Really have to wait until the report is released to the public before we can make our submissions?

AUSTRALIA-NEW ZEALAND HOME BIRTH PUBLICITY WEEK
October 23-30.

Hopefully Branches have not forgotten about this and will be planning the week's activities. So far I have only heard from Auckland that they are organising a public seminar. Wellington are also running a public one day seminar, as well as a slot on the community radio programme 'Access Radio', on Sunday 24th., also display stalls in shopping areas, radio talkbacks with our midwives, an article in the Women's Press and in the main newspapers. They are also going to ask Sharon Crosbie to do interviews with domiciliary midwives and home birth doctors on the 'write-back' programme, accompanied by lots of letters from us home birthers, and one of their members may speak on the 'Opinion' part of her programme.
Could branches please let me know what they are doing so I can write a report in the next national newsletter.

ONE THOUSAND HOME BIRTHS

The Auckland branch have had a member collect and analyse a total of 1,000 home births in NZ over the last six years. This study is now completed and will be published in the NZ Medical Journal, as well as sent out to all Members of Parliament. The statistics will also be published in the information booklet on home births presently being written by the Auckland Branch.

HOME BIRTH-AUSTRALIA

The Australian National Home birth Conference was held in Melbourne from May 17 to 23rd. Joan Donley (Auckland midwife) was able to attend and gave a resume of home birth in New Zealand. Broadly speaking, Homebirth Australia are working for the following:
-Direct Entry Midwifery Training. Although they feel that this is desirable, they also feel that the possibility of such a course being set up in an establishedinstitutions is fairly minimal. The Melbourne group are therefore looking into the possibility of setting up such a course themselves in a less formal and of course 'unrecognised way'.
- Cost. In Australia, domiciliary midwives are not paid by the Government, and generally charge their own fees. They are trying to get more insurance companies to refund parents who have had to pay for a home birth. Presently, some insurance companies will pay for some things.
- Constitution. They are planning to write a national constitution on home birth.
- They want to aim for greater unity of all home birth groups and practitioners. At the moment they seem to have the problems of distance and different laws applying to different states, and the two birth attendant factions, lay midwives, and certificated midwives. They aslo have, in some states, 'birth attendants' whose function it is to attend the woman in labour but not actually delivering her- leaving this to the doctors.
- Birth Centres- they want to actively support these.
-National Spokesperson- Groups to send clippings, etc. of all false or negative statements on home birth to Henny Ligtermoet, GPO Box T 1689, Perth 6001, for her to make public statements.

As yet they do not seem to have formed a proper national body and national executive.

Anti Home Birth Regulations planned for New South Wales.
The Sidney Home birth group are busy trying to stall restrictive regulations on home births in this state.

Midwives on trial in Queensland.
The Queensland Nurses Registration Board is sueing two lay midwives for practising midwifery without registration. This case has arisen because the midwives concerned attended a woman in February, whose labour resulted in a stillbirth. The Capricornia Home Mdwifery Service feel the midwives are entirely free from blame and are concerned that this case may set a precedent in Australia.

ARTICLE IN PARENTS CENTRE BULLETIN

ParentsCentre Bulletin no. 90, Winter 1982 has an article on episiotomy, in which Wellington domiciliary midwife, Lynne McLean, (herself an expert at avoiding this unpleasant interference) writes her views on this topic. The article also contains the views of a midwife from Wellington Women's Hospital, and seems to me to show clearly how hospital midwives are learning from the domiciliary midwives ! The following comment made by her must typify the rather strange attitude of the majority of todays obstetric professionals:

"If a woman/couple take care in choosing their doctor, make their views known to him/her at an early stage, ensure that their views are recorded antnatally, practise the perineal massage(wheat germ oil) andare prepared if necessary to insist (in a normal birth situation) on their wishes being followed, then the woman should be no more likely to have an episiotomy than if she were giving birth at home."

In other words: complete what sounds like an obstacle course and you can have what should be an automatic right for every woman in New Zealand!

"CLOSE UP" PROGRAMME ON BIRTH ALTERNATIVES IN NZ.

The Wellington Branch have been asked to contribute to a "Close-Up" documentary on birth alternatives in NZ planned for October. The programme will look into hospital births, birth centres, home births, and underwater births.

WHAT KIND OF PEOPLE CHOOSE A HOME BIRTH ?

Dave West, a member of the Wellington Branch of the NZHBA,whose wife has recently had a home birth, recently completed a small research project into the type o person who chooses or supports home birth, as part of a Massey University course on Industrial Communications. Below are outlined some of the interesting things he found:

There are significant areas of difference in diet, attitudes to the hospital system, the role of the father in child rearing and around the home, attitudes to the nuclear family, religion, occupation, and degree of involvement in political activities. The differences, he feels, are not necessarily an indication that home birthers form a distinct sub-culture, however. Dave's findings tended to corroborate the comment made by Wellington's domiciliary midwife, Lynne McLean, that "Women electing home birth are genrally highly

motivated toward mental and physical health, may be counter culture to some degree, but keen to be involved in the decision-making, no matter what type of person they may be," and Lewis Mehl's comment (The Outcome of Home Delivery Research'in the US; In Kitinger, The Place of Birth) that home birthers were "quite average people... 90% of them living in a single family dwelling, father gainfully employed, one or two cars, not a member of an ethnic minority, not on welfare, and with no household servants, and having a hard-to-define level of self awareness which manifested itself in an individual concern for nutrition, philosophy, positive health, humanistic psychology, ecology, and the survivalof mankind as a whole".

Diet

The home birther's in Dave West's sample showed that a significantly high percentage of us are vegetarian or eat less meat than 5 times a week, all were keen to avoid processed and packaged foods, preservatives, food additives and chemicals and chose a diet high in fresh and raw fruit and vegetables, wholefoods, and grains.

Attitudes to the hospital System.

Dave notes that "Desire to have a natural birth (free of drugs and medical intervention and in familiar, family surroundings) is one of the major reasons given for support of home birth. Fear or dislike of hospitals is not often cited as a major reason. There is an emphasis on diet and drug free pregnancy and child birth. Home birthers see the hospital environment as being necessarily restrictive and interfering with their desire to take control of, and responsibilty for, their own lives. The sample showed a general dislike for the hospital atmosphere, lack of confidence in the 'medical system', and a feeling that the hospital situation involved relinquishing control of one's own body.

Role of the Father in Childrea ring.

21 of the 37 respondents believed that the father's role in child rearing should be the same as the mother's, and that there should be equal sharing of all child rearing tasks, although many found that this was not possible because of the need of the father to work full time. most home birth fathers are actively involved in the antenatal care and preparation of their ladies, and in the birth itself. They are more active around the home in matters relating directly to childcare (changing nappies, feeding, bathing, playing with the children), and are more likely to help out in other areas to free the mother for more baby-oriented tasks or even having a rest.

The nuclear family

Home birthers overwhelmingly live in a nuclear family situation. Family size is probably larger than the norm, and all respondents were in a couple relationship. A relatively high number were however not happy with their present living situation. Most would like to have closer relations to other people, family and friends, a wider range of people for their children to interact with,and more time to build family relationships.

Dave writes:" Overall, it seems home birthers are more oriented towards living in groups than would be expected in the population as a whole. There is an obvious desire to be living as part of a larger group, or at least as part of a more co-operative group than at present. This is consistent with the general perception of the father (as a 'carer' aswell as a provider) and of the generally co-operative and supportive approach to life in general."

Religion and politics

Here they differ again significantly from the norm, showing a greater degree of involvement in a wide variety of 'political' movements ranging from trade union activity to Amnesty International. Definite religious affiliation seems to be less than the norm.

Occupation and Education
Home birth parents, both mothers and fathers, tend to be more heavily weighted towards the professional group than is the norm. Half of the respondents were university graduates, and half of these again had post-graduate qualifications.

A (MARVELLOUS) BIRTH STORY

By Jenny Woodley (Wgtn).

Our first two children were born quickly but violently in hospital. Seven years and a miscarriage later, Frances was born beautifully easily and gently at home.

I remember the joy of reaching 37 weeks and having an Xray confirm that the baby was not breach (like our first) and that therefore the 'threat of hospital' was virtually over. Home birth meant feeling all the birth - the vague, heavy cold feeling the evening before, waking the same after a good night's sleep and sending the children outdoors to find mushrooms so I could have a quiet 'listen' to what was going on inside, and everyone staying home 'just in case'.

The body has its own analgesic system, I'm sure. By the time we called Lynne to come that morning, I was wrapped in 'cooton wool' and feeling actually pleased that our Van Gogh print is faded to quiet hues. When she arrived at 10.15 her first task was to help me undress, and by 10.30, after 5 marvellous pushes (Keith counted as he held me close) we had a warm, wet wee body to love and admire! All so easy and uncomplicated! It was then that I sensed an overwhelming sense of relief that we were safe together at home and there were no threats to our integrity. We didn't manage any birth photos, but printed forever in us will be the sight and smell and warm wet heaviness of our littlest girl as she lay snuffling quietly on my tummy. Now my vague instincts that birth could and should be like this were affirmed for us- now we knew.

Nine year old Rachel watched the whole procedure and was somewhat overwhelmed with conflicting emotions in spite of all our preparatory talks and looks at birth photos etc. - her first reaction was 'yuk' and feelings o jealousy and rejection, along with a concern for the baby's and my well-being. Seven year old Ben, my parents and the family dog arrived in time to see the last push and baby born. Ben told his teacher over the phone that "We got our baby out today" and that it (the baby) was "quite revolting really - all purple with spots all over" !

In the days after the birth we marvelled at how uncomplicated life was without hospital procedures. It was marvellous to have Lynne visit and help me conquer for the first time, the art of breast-feeding. I appreciated so much her low-key expectation that I would feed successfully, as a contrast to the anxiety-ridden, doubtful approach that had shriveled my confidence in hospital.

I feel confident now in coping with the amazing amount of hostility still expressed by people, mostly in veiled terms as in the oft-repeated question "Is she a good baby?" or that if you feed"too long" you'll get "run down", or that I was just "lucky" to "get away with" a home birth, or the insinuation that it's somehow disgusting and definitely abnormal to enjoy birth, and that our baby must have been such a surprise for us (it's apparently

impossible to imagine anyone actually planning a pregnancy these days at the age of 35 - we must have just been disgracefully careless !) and so on.....

Home birth has been for me a new experience in loving acceptance, free of condemnation, and something inespressibly fulfilling. Perhaps the only possible way to thank all those who helped, especially Lynne, is to keep growing in this newfound confidence, and to keep seeking to ensure that Frances' life continues as it began - in the best possible way !

****

HOME BIRTH AND WOMEN M.P.s.

The Wellington branch has established a positive relationship with Labour M.P, Fran Wilde, who has indicated her support for the home birth option and agreed to give an opening address at a public seminar on home birth at the beginning of home birth publicity week.

Henriette Kemp has written to Ruth Richardson and Marilyn Waring, who have both indicated their support for the home birth option and want to receive the national newsletter.

The Christchurch branch have been establishing contact with Ann Hercus (Labour's spokesperson on Health), who is addressing the Christchurch group to discuss the legality of home birth and the current political situation of home birth.

We hope that other branches will initiate personal contact with their local MPs, male or female , soon, and let us know about the outcome.

NEWS FROM OTHER BRANCHES.

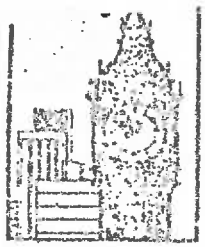
DUNEDIN

The Dunedin Home Birth Association is about to enter its 5th. year of offering support to and information to people interested in home birth. From small beginnings, lots of enthusiastic people but no professional support, we now have lots of enthusiastic people including two competent domiciliary midwives and several doctors. Home births have risen from one per year to approximately 15 per year. Interest in birth at home, from professionasl and parents is continuing to increase. The Association now gives regular talks to medical students, 3rd., 4th. amd 5th. year; nursing students, and a variety of parent groups.

Unlike some other centres in NZ, Dunedin is fortunate in having sensible Principal Public Health Nurses who see the value of helping rather than hindering registration of our Midwives. Ngaire Witte has joined the ranks of the elite and is now a registered Domiciliary Midwife.

WELLINGTON

Lynne McLean has been very busy 'holding the fort' on her own after our Hutt midwife stopped practice. We now have another midwife, Pam Skelton, who will be starting soon. We have had to spent quite some money on equipment for her and purchsed an answerphone for Lynne as well. The branch is now also involved in running and participating in antenatal classes.



PETER KELLNER, Political Editor

Bureaucrats versus free choice

LAST WINTER Mr Brian Radley and his common-law wife, Ms Michelle Williams, decided that their second child should be born at home. They informed the West Midlands Area Health Authority of their wishes. Mrs Mary Evans, a highly experienced local midwife, visited the couple; she regarded their wishes as unreasonable, and refused to arrange a home confinement. Two weeks after Mrs Evans's visit, the couple's child was born safely into Mr Radley's arms at home.

The health authority did not approve. Mr Radley's actions, they felt, contravened the 1951 Midwives Act. He was prosecuted on the grounds that 'being a male person, you attended a birth otherwise than under the direction and supervision of a duly qualified medical practitioner'. Under the Act, Mr Radley was only entitled to deliver his own child if there was 'urgent necessity' for him to do so. The health authority argued that there was not; the magistrate agreed. Last Friday Mr Radley was fined £100.

Perhaps the most ominous aspect of the court case was hidden in the question of why, having won the case, the health authority did not press for costs to be awarded against Mr Radley. Mr Ian Morris, appearing for the authority, said it was 'because the case has been brought to protect others'. That is, a little-used part of the 1951 Act has been revived to launch a test case. Woe betide any future couple which behaves in the same way, especially in the west Midlands. Unless the magistrate's decision is reversed on appeal, a new line has been drawn, that is both medically absurd and politically dangerous, between the rights of the individual and the power of the state.

IN THE CASE of Mr Radley and Ms Williams, three issues need to be disentangled. First, are the *general* arguments against home confinements strong enough to justify the overwhelming thrust of NHS policy and resources towards the provision of hospital rather than home maternity services? Second, were the *specific* requests of Mr Radley and Ms Williams medically unreasonable? Third, what role should the law play in upholding the rights of parents?

The general argument for hospital rather than home confinements was exemplified by the introduction to the otherwise excellent *Newsnight* report on BBC-2 last Friday. It showed how births in hospital, as a proportion of all births, have risen sharply during the past 30 years, while perinatal mortality has fallen sharply. The conclusion seemed inescapable: the one caused the other, so having a baby in hospital is safer than having a baby at home.

This argument is sheer nonsense. It has been demolished so effectively by Marjorie Tew[1] that it is a wonder that anyone still deploys that particular case.

As Ms Tew says, it is dangerous to draw cause-and-effect conclusions from long-term time series that seem at first sight to go together:

> The secular decline in the mortality rates could as readily be shown to correlate with the secular increase in motorway mileage or television licences.

To show cause-and-effect, more sophisticated statistical tests need to be done. The main test is to look at the figures year by year. Do the mortality rates fall faster (or slower) than average during years when the rate of hospital confinements rises faster (or slower) than average? When this test is applied to the figures, no clear pattern emerges. In other words, the long-term fall in mortality rates, and the long-term rise in hospital confinements, have no clear causal link: they are the separate result of different forces, to do with the pattern of NHS care, rising standards of living, and general improvements in health and nutrition.

> **... a new line has been drawn, that is both medically absurd and politically dangerous, between the rights of the individual and the power of the state.**

Comparing present-day mortality rates by birth in hospital and births at homes is a hazardous business. Overall the figures for perinatal mortality at home are much higher than in hospital. But this is largely because so few births are *planned* to take place at home (about one per cent of all births) that a significant proportion of births that actually take place at home are emergencies. It is not surprising that in these circumstances many babies born at home are still-born or die within a few days. What official figures do not show is the perinatal mortality rate for births *intended* to take place at home. Analysing the studies and statistics that have been provided, Marjorie Tew concludes:

> The published statistics, as far as they go, show that the risks for infant and mother are in many categories *lower* when the birth takes place at home.

SOME PROGRESS has been made in prompting the NHS to take a more sympathetic view towards home deliveries. Shortly after the present Government came to power, the health minister, Gerald Vaughan, wrote to the Childbirth Trust to state:

> '... It is also our policy that mothers who choose to have their babies at home, despite the arguments against it, should be able to do so and health authorities should ensure that the necessary services are provided to make home confinement possible.'

This does not concede the medical argument about where birth *should* take place; but no matter. Was the West Midlands Health Authority acting in breach of Government guidelines?

Here the issue becomes more specific. Ms Williams wanted to give birth in the 'squatal crouch' position; she rejected the use of all drugs; and she wanted Mr Radley to deliver the baby — though with a midwife in attendance.

There is no consensus among doctors or midwives as to whether this is safer or riskier than other forms of birth for women like Ms Williams. It was her second pregnancy; there had been no medical problems with her first birth; she was 20 years old, and so in the age group where the risks are lowest. One of London's most experienced home-delivery GPs told me: 'I can think of no earthly reason why the couple shouldn't have had the baby the way they wanted. Damn few people are allowed to make few enough important, unfettered choices these days. Surely where and how to give birth to one's children should be one of them.'

This is broadly the view of the National Childbirth Trust and the Radical Midwives Association.[2] But Mr Radley and Ms Williams did not have ready access to a doctor or midwife who shared the view. And because the law did not protect their right to exercise their choice in the face of contrary medical advice, they have been punished.

It would, perhaps, be a trifle unrealistic to expect the law to be changed immediately to clarify the right. There is, though, a simpler solution. Norman Fowler, the Social Services Secretary, has shown a willingness to sack health authority chairmen who step out of line with Government policy. He should now assert that parents have the unambiguous right to choose how and where their babies are born, and that any future prosecution similar to that launched by the West Midlands Area Health Authority would be an improper and inadmissible use of public funds.

That would, perhaps, spur the NHS to improve on its patchy home delivery service. My wife and I are lucky. Our GP actively supports couples who want their children born at home: the second and third of our three children were, after my wife had become disenchanted with the way she had been treated in hospital at the time of her first confinement. Had Brian Radley and Michelle Williams lived in our part of London, they would have had no trouble. Had we lived in Wolverhampton, I shudder to think what would have happened to us.

1. *The case against hospital deliveries: the statistical evidence*; in *The Place of Birth*, edited by Sheila Kitzinger and John Davis, OUP 1978, £10.
2. Both organisations can be contacted at 9 Queensborough Terrace, London W2 3TB.