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Risk and homebirth: what’s at stake?

By Karen Lane and Kerreen Reiger
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In the aftermath of the recent federal Review of Maternity Services, public debate on the relative merits of home versus hospital birth has been raging with more heat than light. Current affairs coverage of the topic has at times attracted the worst practices of the tabloid press. Alarmist headings such as “Why hospital horrors bring birth risks home” (*Daily Telegraph*, April 6, 2009) are not helpful to anyone engaged in this debate - not women, not midwives, not obstetricians and not policymakers.

As maternity service researchers and as mothers we make three arguments here. The first relates to media coverage of the topic. The second relates to the international evidence surrounding the safety of homebirth. The third relates to the future provision of optimal maternity services for Australian women.

First, news reporting that uses sensationalist and simplistic strategies to attract a popular readership neglects its public responsibility and imposes loss of integrity on the newspaper, its editors and reporters. Of course it is commonplace to resort to sensationalism and to reduce complex factors to dot points and one-liners but this fails to serve an inquiring and concerned public and fails to support genuine public debate. Reducing the complexity of the home versus hospital debate to a vacuous, vote “yes/no” quiz or to a journalist’s preference for extreme stories (for example, the *Sydney Morning Herald*, April 7, 2009) is hardly enlightening.

Public sector broadcasting has not been immune from the problems: the well-regarded *Insight* program (SBS, March 10, 2009) started its discussion of childbirth by using graphic images of caesarean births and stressed professional “turf wars”; and the ABC’s *7.30 Report* (April 1, 2009) was guilty of clipping key comments from both a senior midwife and a leading obstetrician to produce a different meaning from their original statements. This is not just fraudulent; it undermines the professions’ reputations, and it has recently intensified divisiveness and anguish within and between them. Most of all, it is dangerous for the well-being of women, their babies and families who require health professionals to work collaboratively and with mutual respect to achieve high levels of access, universal standards and safety.

Second, the question of the safety of homebirth needs to be contextualised within debates over evidence-based practice and reviews of randomised control trials - seen by the medical profession as the gold-standard in assessing various treatment regimes.

According to the most recent review updated in April 2006, the internationally respected Cochrane Collaboration reported that “There is no strong evidence to favour either planned hospital birth or planned home birth for low-risk pregnant women”.

Further, “The change to planned hospital birth for low-risk pregnant women in many countries during this century was not supported by good evidence. Planned hospital birth may even increase unnecessary interventions and complications without any benefit for low-risk women”.

A recent large retrospective cohort study in Holland where 30 per cent of women typically birth at home found “no significant differences between women who gave birth at home with those who had a planned hospital birth”. Mortality and transfer to a neonatal intensive care unit was the same in both groups, namely 7 per 1,000 births.

Anecdotal evidence that in an area of New South Wales recently there have been one or two extra deaths per 1000 births fails to provide evidence about anything and may rightfully be dismissed as sensationalism and political opportunism. Unfortunately, deaths occur both at home and in hospital; the vast majority are not related to setting of birth.

Earlier studies have come to much the same conclusion, although there are some that claim much better mortality
and morbidity rates for home birth.

The issue of safety hinges not simply on the woman’s physiological status before and during birth, or the health of the baby *in utero*, but how the woman experiences her social environment throughout labour. Physiological childbirth is a complex process which we are learning more about all the time. We do know that it is neither mechanical nor entirely predictable. Published meta-analysis of continuous social support for labouring women (emotional, comfort measures, information and advocacy) indicates that it seems to enhance outcomes as well as increase “women’s feelings of control and competence and thus reduce the need for obstetric intervention”.

The social and physical environment matters because it actually *shapes* what happens. Midwifery care helps *create* normalcy; a low-risk birth can actually depend upon social relationships with carers to achieve calm, control and confidence in the process. This is where midwifery care in *collaboration* with expert obstetric advice when needed comes in. It is also why many women want to exercise their human right to stay where *they* are in charge not medical experts.

The third point is that to achieve optimal maternity care for women in the future requires transcending ill-informed debates about the relative safety of home and hospital birth. Midwives are accredited through formal processes, and those attending homebirth are frequently the most highly qualified and experienced. Across Australia, new forms of care are already extending birthing options, but exciting opportunities and even safety are also being compromised. Funding inefficiencies, especially through public support for the private sector, overcrowding, and over-stressed staff in many hospitals, and loss of rural services due to staff shortages are the big policy challenges.

While professional tensions remain, our recent research into professional relationships in Australian maternity care has found new forms of knowledge-sharing and collaboration. For example, in several major women’s hospitals, homebirth transfers are now handled amicably and responsibly. The key question is how best to deliver healthy birth options in hospitals and homes, including provision of necessary professional indemnity insurance. Real safety is assured when we endorse models of care that incorporate reciprocal respect and recognition between midwives and obstetricians in the sole interests of women and their families. As Minister Roxon rightly commented on *Insight*, this is the essence of the Maternity Services Review recommendations.

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