Home or hospital: What's the big deal?

In this article Ruth Hungerford asks the questions: How did hospital birth become the norm in New Zealand? And does it matter?

Prior to European colonisation of Aotearoa New Zealand, 100% of births took place in the home. Whilst some European women birthed in public hospitals as early as 1882 the number who did so was minimal and up to the 1920s home was still the usual birthing place for the majority of New Zealand women (Banks, 2000). In 1920 most births were still occurring at home with 35% of births taking place in hospitals. However by 1926, 58% of births were occurring in hospital and by 1938 this number had risen to 87% (Banks, 2000). In 2003 over 95% of births in New Zealand take place in hospital. So, what happened? Why did birth move from the home to the hospital? and does this really matter?

A gallop through birth herstory

In the mid 1800's childbirth for New Zealand European women happened at home and lay midwives were the primary birth attendants. These women supported women in childbirth and often assumed responsibility for looking after the woman's family and household while the mother recuperated (Banks, 2000; Donley, 1986). For Maori women, childbirth was centred around the family, with the birthing processes traditionally attended by mother, grandmother, tohunga (spiritual healers) and other relatives.

Lay midwives were generally regarded within their communities as women who possessed considerable skills and despite the harsh pioneering conditions consistently good outcomes were reported for mothers and babies. For example in one West Coast town in 1894 there were over 400 births attended in turn by one of three married women. Of these not one mother died and no doctor ever attended (Greymouth Branch of the National Council of Women, 1959 cited in Banks, 2000). Lizzie Lean, a Dunedin midwife in the 1890s "delivered [sic] a thousand or more babies on her own" and never lost a baby (Donley, 1986, p. 27) Alison Drummond claims that between 1814 and 1840 not one European woman died in childbirth (cited in Donley, 1986, p. 28).

However the Midwives Registration Act in 1904 signaled the beginning of the end for the lay midwife. The Act set up St Helen's Maternity hospitals and provided training for midwives. Lay midwives who continued to practice had to be certified for registration by a doctor (Banks, 2000; Donley, 1986).

Other laws also changed childbirth practices for both European and Maori women. For example, the Tohunga Suppression Act of 1908 caused traditional Maori birth practices to go underground, and the passing of the Nurses and Midwives Registration Act of 1925 saw birth attendance become unlawful practice unless that person was a doctor, a certified lay midwife, or a registered maternity nurse or midwife (Banks, 2000). As a consequence of these laws, the traditional birth attendant for women all but vanished.

Pregnancy and birth becomes a disease

Up to the 1920s pregnancy and birth were generally viewed as normal states of health and as such did not entirely fit within the medical domain, which is concerned of course with ill-health or disease. In fact in the 1920s the Minster of Health advised women to have neither doctors nor anesthetics during labour. This was because the presence of doctors was associated with an increased rate of puerperal sepsis (childbed fever) as practices such as vaginal examinations and forceps deliveries were commonplace and contributed to infection. Midwives did not commonly practice these so their rates of puerperal sepsis were significantly lower than that of doctors (Banks, 2000; Donley, 1986; Mein Smith, 1986).

Childbed fever or puerperal sepsis - an infection of the uterus which in severe cases results in death – was one of the key causes of maternal deaths. Rich (1986) notes that the occurrence of childbed fever was *"directly related to the increase in obstetric practice by men… With the growth of lying in hospitals in the cities of Europe, the disease, rarely known in earlier times – reached epidemic proportions. In the French province of Lombardy in one year no single women survived childbirth."* (cited in Banks, 2000, p.64)

Today it is accepted that childbed fever is an acquired infection – that is it is caused by germs introduced into the woman's body by others – the primary way that this occurs is through vaginal examinations carried out with unclean hands although other procedures such as forceps deliveries and surgical interventions are also ways that infection is transmitted. This was determined as early as 1848 by Ignaz Semmelweiss who identified 'putrid particles' (germs) as the cause of puerperal sepsis. However until 1935 the Obstetrical Society in New Zealand held to the belief that childbed fever was caused by virulent organisms lying dormant in the woman's body which for no apparent reason became active after birth causing infection (Banks, 2000; Donley, 1986).

Ironically the high rate of puerperal sepsis was one of the catalysts that resulted in birth becoming medicalised as it paved the way for birth to be reclassified from a normal physiological process to a state or ill health or disease. Thus it was that in 1937 The Obstetrical Society declared that labour, by the process of civilisation had become 'abnormal and pathological' and was now a 'surgical operation" and that even the seemingly normal case was "fraught with pain and penalty". Birth was on its way to becoming a 'medical condition'. But it was the lure of pain relief that cemented the move to hospital (Banks, 2000).

So what about pain relief?

Birth is painful. Over the centuries midwives and women have worked together to help women to bear the pain of childbirth using methods such as changing positions, warm water, massage, and support. Scientific studies of birthing women have 'discovered' the endorphins which women produce during labour and which act as a natural pain relief. Research has also shown that women have higher pain thresholds during labour (Donley, 1986) and that women having home births (without drugs) frequently report experiencing less pain that women having hospital births.

Drugs of the pharmacological kind claim to block out physical pain (although some merely sedated the woman and caused amnesia, thus she experienced the pain but did not remember it). The Department of Health initially opposed anesthetising drugs in childbirth as they were correlated with an increase in forceps deliveries (Banks 2000; Donley 1986). However the lure of pain-free labours was strong and despite a lack of knowledge about the impact of pain relieving drugs on mother and baby, sedation and the use of anaesthetics for labouring women became widely used in New Zealand in the 1930s and 1940s.

Today, despite the evidence of negative and tetragenic (something which can damage foetal genetic development) effects on mothers and babies, interfering with breastfeeding and bonding, and their use contributing to increased operative deliveries, drugs continue to be used widely in labour and birth (Brackbill, Rice, & Young, 1984)

But is birth safe?

As medicalised birth gained momentum, hospital births became recommended to women as being the 'safer' option compared to birth at home. Hospitals were perceived as providing a hygienic environment, necessary obstetric interventions and pain relief, all of which women were assured ensured the safety of both mother and baby.

A study conducted by the Society for Research on Women in New Zealand (1985), for instance, found that eighty percent of women within their sample considered hospitals safer for giving birth than home delivery.

The well-established norm of medicalised births saw health departments advocate only for hospital birth. In 1985, for instance, the Department of Health in an about-face from it's 1920s stand, suggested that mothers should have their babies in hospital because "no delivery can be regarded as normal until it is over" (Donley, 1986, p.27).

So is hospital birth safer than home birth? Actually, no. And in fact the reverse is true. Study after study has shown that when "matched samples of women planning to birth at home are compared with women planning to birth at hospitals, the outcomes for women and their babies with planned home births are more favourable and they have less complications. Even when the outcomes of home birth transfers are included, babies whose mothers plan to birth at home have better outcomes and fewer interventions than those of planned hospital births" (Banks 2000, p.113)

Campbell and MacFarlane from the National Perinatal Epidemiological Unit in Oxford stated *"There is no evidence to support the claim that the safest policy is for all women to give birth in hospital . There is some evidence that morbidity is higher amongst mothers and babies delivered and cared for in institutional facilities in general and … obstetric units in particular"* (1986, cited in Goer, 1995)

To sum up…

Birth moved from home to hospital in the space of one generation. The normal birth at home was superceded by the medicalised birth in hospital. The medicalisation of birth was not some great conspiracy or caused by one particular incident. It was a combination of laws that outlawed traditional practices or made them difficult to continue, concerns over the maternal mortality rate and the lure of pain relief.

And does it matter? Yes. Birth in hospital is has more risks and causes more trauma for women and babies. Who does not know a woman with a 'war story' about birth? Consider these facts:

- Support groups for woman recovering from traumatic birth experiences have recently sprung up in our country.
- The cesarean section rate in New Zealand is 22.1% and rising (Report on Maternity, 2002). The World Health Organisation (WHO) notes that cesarean rates above 15 percent represent a danger to women and babies.
- A first time mum in New Zealand today, who births in a hospital facility, has a 50% chance of a cesarean or an operative delivery (forceps or ventouse).
- The effect of obstetric drugs is well documented yet they continue to be used in most hospital births (Brackbill, Rice, & Young, 1984).

The World Health Organisation in 2002 stated that 80% of women should have a normal birth with no intervention. Birth is a powerful, affirming, normal physiological process. If allowed to proceed naturally, birth reinforces family bonds, empowers women and enhances their self-confidence all of which they need to effectively mother their babies (Donley, 1986). Evidence shows that home birth supported by a home birth midwife provides the best possible opportunity for women to regain responsibility for their own reproduction and to have a normal, natural birth.

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