Commentary

From Hospital Deliveries to Home Birth

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Abstract

Working in a busy labor/delivery unit gave me insight into the care that my Lamaze childbirth education students would encounter. I was troubled by the number of interventions taking place. The interventions interfered with a woman's ability to work with her labor; some interventions were actually creating problems or even crises. My experiences at this hospital motivated me to become involved with home birth, restoring my belief that birth is a normal process.

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The labor and delivery unit was busy. I was caring for one labor patient and admitting another. As I walked through the nurse's station a coworker commented on the central monitors. The fetal heart tones in Room 5 showed diminished variability. "Doesn't look great," I agreed.

Two hours later I was finishing my charting and the fetal heart tones in Room 5 had not improved. "How far along is she?" I asked. The nurse who was caring for this patient responded, "Five centimeters." Agreement among the nurses at the desk was that the attending doctor should be called in. The doctor came within 20 minutes and headed down to Room 5.

Fifteen minutes later the emergency light was on in Room 5, and I hurried down to help. The baby's head had delivered, and the doctor was struggling to deliver the shoulders. I was astonished that labor had progressed so rapidly. This patient's nurse and I supported the woman's legs and pushed her knees toward her armpits. Mi-

minutes passed and the baby's shoulders did not budge. The resident doctor was called. We were applying suprapubic pressure and urging the woman to push. Was it 5 minutes now since I had entered the room?

Finally, at least 6 minutes from the birth of the head, the baby was out, limp and blue. The neonatal resuscitation team went to work. One half-hour later, the infant was pronounced dead. The baby weighed 10 pounds, 8 ounces.

I went home in a state of shock. How could this happen? We were in a highly equipped hospital. Why did this baby die?

I had become increasingly uncomfortable with the number of interventions taking place in the hospital. The use of pitocin was escalating, the bag of waters was routinely broken, and everyone was encouraged to take an epidural. The monitors and epidural anesthesia limited position changes in labor. In fact, the mother of the dead infant (who was gravida 6, para 5) had been stimulated with pitocin even though her labor was slowly progressing. Her body had responded rapidly to a low dose of pitocin.

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More than once I had thought about finding a position outside of the hospital. I was aware of a group of doctors doing home birth. As I wrestled with the conflicts that I had with hospital interventions, I picked up a book on home birth by Sheila Kitzinger (1991). I found a chapter on complications of labor, then a section on shoulder dystocia. Ms. Kitzinger writes:

Shoulder dystocia may occur because the woman has had oxytocin which has produced artificially strong contractions that have forced the pace, propelling a big baby along the birth canal before all the tissues have fanned out. The head shoots out and the shoulders are impacted. Women giving birth outside of the hospital should never have labor stimulated with oxytocin, so labor tends to be slower and gentler" (1991, p. 156).

The words leaped off the page and I absorbed them. I made my decision and picked up the phone to call the

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home birth group. Then, I wrote my letter of resignation for my hospital position.

As of this writing, it has been three months since I started working with the home birth practice, and I have attended 12 births. Some of the labors were quick, others were long. A couple of labors had a prolonged pushing phase. One baby weighed 10 pounds, 4 ounces. Through these experiences, I have made some observations that were startling.

The first two births that I attended were for the purpose of orienting to the home environment. As I observed each laboring woman move through labor, making requests of family and the nurse in attendance, I was struck by the fact that each woman was the center of attention. Everyone was paying attention to her requests, her instincts, her emotions. The laboring woman is the center of attention at a home birth in the same way that a bride is the center of attention at a wedding.

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I also noticed that each of the women had distinct preferences for how they labored. Sharon walked through early active labor, sitting occasionally. When labor intensified she sat in a warm-water bath. Eventually she positioned herself in a semi-sitting position in bed. Emily alternately reclined in bed and squatted while her husband and her nurse supported her positioning. These women had distinct preferences for how they labored.

Sometimes the nurse, midwife, or doctor would sug-

gest a position or offer massage. The medical staff was watchful and attentive. The fetus was monitored by Doppler. The attentiveness was quiet and ready but not intrusive.

I have taught Lamaze International childbirth education classes for 18 years. My goal has been to equip women to work with their bodies. This was the best demonstration of women working with their bodies that I had ever seen. There were moments of stress with calm suggestions by those in attendance; but, for the most part, the women were in a state of focused physical work. They were assisted by massage, slow breathing, water therapy, panting. I was intrigued. There seemed to be an intrinsic relaxation factor supplied by the home environment.

It is not uncommon to have stressed infants in the hospital. In the hospital, we use radiant warmers, blow

by oxygen, and employ aggressive management of low blood sugar. In the home environment, as I witnessed prolonged pushing, a cord around the neck, and a compound presentation, I anticipated a need to resuscitate. I was amazed at how well these infants responded. They seemed to have a greater reserve for reacting to stress. They breathed spontaneously and were placed on the mother's chest, skin-to-skin contact. The mother's body acted as the radiant warmer. The infants' blood sugars were all normal.

Dr. Mayer Eisenstein coordinates Homefirst® Health Services, which provides physician-attended home births in Illinois. Dr. Eisenstein has gathered some amazing statistics in his book, *The Home Birth Advantage* (2000). It is a good read for orienting one to the benefits of home birth. It also presents a discussion of safety issues (see Table 1). Likewise, Henci Goer, a Lamaze Certified

Table 1 Eleven Home Birth Principles for Safe Birth*

1. A trained doctor must be completely in charge of the birth.
2. The mother should have adequate prenatal care.
3. Doctors and nurses must be in constant attendance at the labor.
4. The medical staff must have adequate equipment with them in the home.
5. The doctors must employ simple, intensive, aseptic technique.
6. The laboring mother must be in a favorable environment, her own home.
7. There should be a minimum of operative intervention in the birthing process. Less than 1% of the babies should be born by cesarean section.
8. Good hospitals should be available as backups for the doctors delivering babies at home.
9. Doctors should take action early in the event of hemorrhage and know proper hemorrhage control.
10. There should be no interference permitted in the third stage of labor.
11. No pitocin should be used until after the birth of the baby. If any doctor disregards this rule, he should be dismissed from the practice.

*These eleven principles were developed by Dr. Beatrice Tucker (director of the Chicago Maternity Center from 1932 until 1972) and presented by Dr. Mayer Eisenstein in his book, *The Home Birth Advantage* (2000, p.37-38).

Table 2 A Summary of Evidence that Addresses the Safety of Home Birth*

1. Raw data, such as birth certificates, give an inaccurate picture of the risks of home birth because they include a large proportion of unplanned births and births without a trained attendant, both situations carrying an extremely high risk.
2. No study of planned home births of a screened population of women with a trained attendant taking proper precautions has shown excess risk.
3. Because unexpected problems arise even within a screened population, those planning home birth should have appropriate backup arrangements with an obstetrician and a hospital. Home birth attendants should have the skills, equipment, and medication to manage or stabilize emergencies such as a baby who does not breathe spontaneously or a mother who hemorrhages after birth.
4. Home birth becomes dangerous only when doctors and hospitals fail to provide backup services.
5. Excellent outcomes with much lower intervention rates are achieved at home births. This may be because the overuse of interventions in hospital births introduces risks or the home environment promotes problem-free labors.
6. An ultrasound scan may be advisable in late pregnancy to rule out twins and breech presentation (and to confirm placental location).
7. To prevent unnecessary postpartum hospital transfer, the attendant should be able to repair perineal lacerations and to perform and repair an episiotomy.

* From: Goer, H. (1995). *Obstetric myths versus research realities*. Westport, Connecticut: Bergin & Garvey (p.334-335).

Table 3 Additional Resources on the Safety of Home Births

References

- Ackermann-Liebrich, U., Voegeli, T., Gunter-Witt, K., Kunz, I., Zullig, M., Schindler, C., & Maurer, M. (1996). Home versus hospital deliveries: Follow-up study of matched pairs for procedures and outcome. *British Medical Journal*, 313, 1313–1318.
- Olsen, O. (1997). Meta-analysis of the safety of home birth. *Birth*, 24, 4–13.
- Schlenzka, P. F. (1999). *Safety of alternative approaches to childbirth*. Unpublished doctoral dissertation, Stanford University, Palo Alto, CA. [Brief review available at <http://vbfree.org/safety/meadsum.html>]

Web Sites

www.changesurfer.com/Hlth/homebirth.html
www.homebirth.org.uk/homebirthindex.htm
www.homefirst.com

Childbirth Educator, has written an excellent book, *Obstetric Myths Versus Research Realities* (1995). In her chapter on home birth, Goer includes 23 research abstracts and offers summaries of the significant points (see Table 2). Additional resources on the safety of home birth are listed in Table 3.

Recollections of Dr. Grantly Dick-Read's book, *Childbirth without Fear* (1985), have also come to my mind, lately. I have picked up a copy and am now rereading it. Many years ago, Dr. Dick-Read noticed the contrast between women laboring and giving birth at home and women giving birth in the hospital. He devoted his life to studying the process of birth. Dr. Dick-Read con-

cluded that birth is a normal physiologic process that encompasses the body, mind, and spirit of a woman.

Since my involvement with home birth, joy has been restored to my work. I have a renewed confidence in a woman's ability to give birth without intervention. I was on my way to burnout; now, I have a renewed appreciation for the normal process of birth. When I return to the hospital environment it will be with renewed energy to assist women to birth normally.

References

- Dick-Read, G. (1985). *Childbirth without fear: The original approach to natural childbirth*. New York: Harper & Row Publishers.
- Eisentein, M. (2000). *The home birth advantage*. CMI Press. [www.homefirst.com]
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Moving Forward with Confidence

The undertaking of a new action brings new strength.

—Evenius

Change has a considerable psychological impact on the human mind. To the fearful it is threatening because it means that things may get worse. To the hopeful it is encouraging because things may get better. To the confident it is inspiring because the challenge exists to make things better.

—King Whitney Jr.

Whatever you are by nature, keep to it; never desert your line of talent.

—Sydney Smith