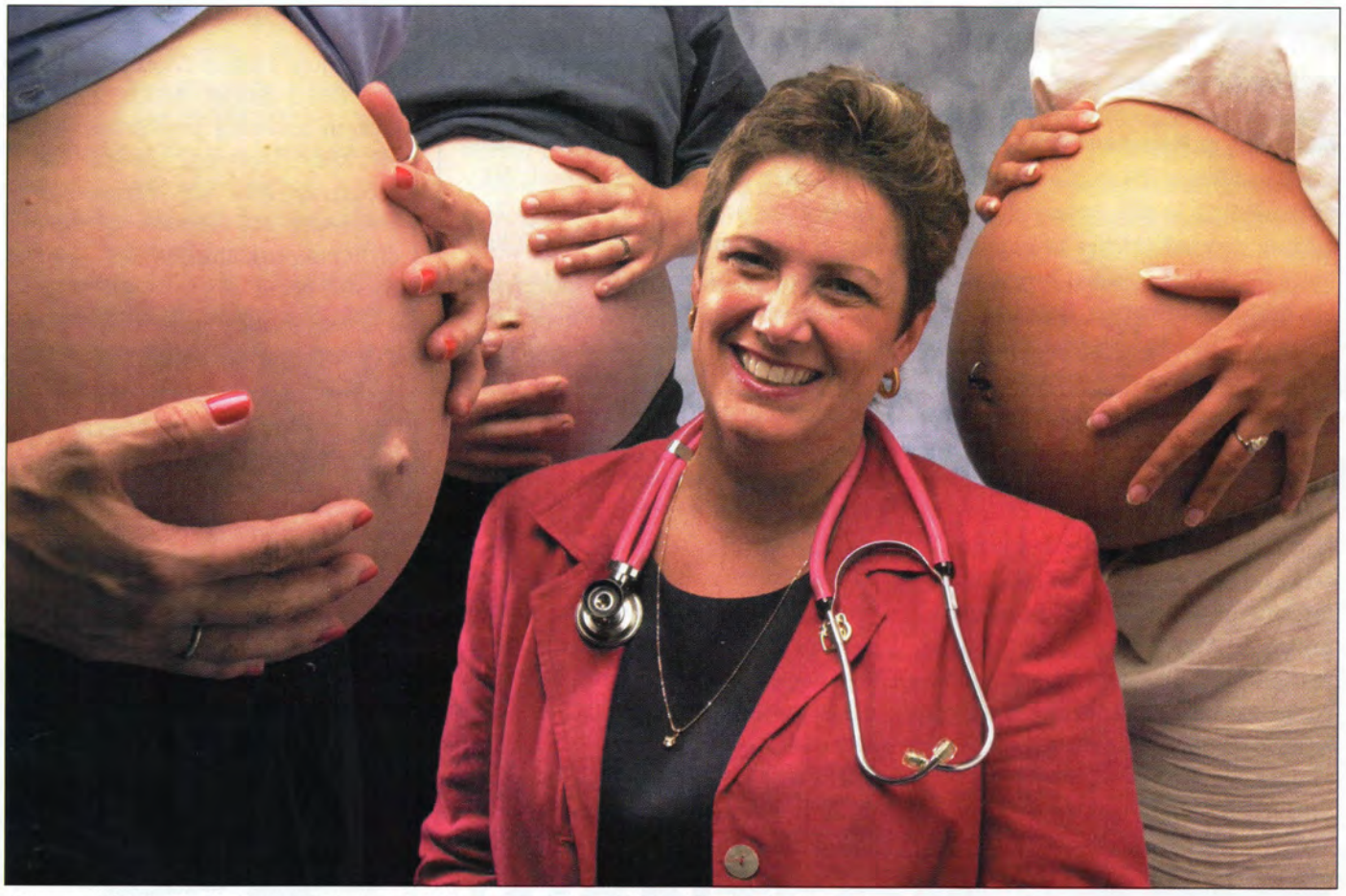
POLITICS AS UNUSUAL

Home-Birth Debate

Acceptable alternative or prescription for disaster? Physicians and midwives share their views.

By Laurel DiGangi



Julie Jacobson/Kansas City Star (KRT)

Nurse-midwife Sheila Roth has helped deliver more than 600 babies during her 14-year career.

"Home delivery is for pizza, not babies." That's the official response from Lawrence Bruksch, MD, when asked how he feels about women who choose the personal—and controversial—experience of delivering their babies at home.

"I wouldn't want my daughter or someone I care about to have a home birth," says Dr. Bruksch, a Los Angeles ob-gyn who has practiced for 22 years.

His feelings are shared by most of his colleagues. When asked if women should be allowed to choose home birth as an option, Riverside ob-gyn George Jukkola, MD, asserts "everybody has the right to kill themselves, but I don't think it's something that should be advanced onto another generation."

Physicians cite numerous potential risks to both mother and child when an infant is delivered at home: acute and severe toxemia, uterine hemorrhage, abruption of the placenta or a prolapsed umbilical cord.

"If the heart rate is down from a prolapsed cord and you can't get the baby out in five minutes, the baby is going to die or be permanently injured," Dr. Bruksch says. "So, a baby can be the unwitting victim of a poor decision by his or her parents."

The "Home Court" Advantage

Despite these warnings, many educated women demand to deliver their infants at home, typically under the care of a midwife. Their reasons vary, but most seek a more fulfilling birth experience than that associated with a hospital setting or even a birthing center. These women regard birth as a family event and want to remain on familiar ground, surrounded by whomever they choose to be present, including their children.

They also believe giving birth at home will enable them to be more relaxed and lose their inhibitions. They'll be freer to make as much noise as they want; try various positions, like squatting or getting down on all fours; and explore alternate methods of pain relief, such as taking a warm bath or a stroll in their backyard.

These women also wish to avoid medical interventions, which they feel are unnecessary to their and their infants' health and well-being.

"Many physicians think of pregnancy as a medical condition over which they have to exercise control, so they intervene because 'why not?'" says Melanie Austin, RN, CNM, NP, MPH, president of the California Nurse-Midwives Association. "They're more likely to offer medication for pain relief and epidurals, rather than waiting until all other things have failed to work."

And for California women who are strongly determined to deliver at home, a physician-assisted birth is not an option. Physicians risk losing their malpractice coverage, so that's when women turn to one of several types of midwives (see sidebar, page 32).

While most physicians believe home birth jeopardizes the health of mothers and their infants, most licensed midwives insist that, statistically, home birth is just as safe as delivery in a hospital or birthing facility.

"There's no evidence that home birth is less safe than hospital births," says Austin.

She's backed by the state's SB 1479, which states, "California studies suggest that low-risk women who choose a natural childbirth approach in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to the hospital."

The Catch-22 of Home Birth

A licensed midwife must, by law, maintain a working relationship with a physician. The California Business and Professions Code specifically requires

midwives to have the "supervision of a licensed physician and surgeon."

Because physicians want to avoid losing their insurance, virtually none are willing to supervise in this capacity.

Carrie Sparrevohn is a licensed midwife and chairperson of the California Association of Midwives, an advocacy organization. When a home birth develops complications that require hospital intervention, the midwife will often be met with hostility by the staff, even when no harm has been done to mother or baby, she notes.

"These cases often get reported to the medical board because the midwife doesn't have supervision," Sparrevohn says, "but we can't get supervision because no doctor will supervise us. It's a medical catch-22."

In addition, the American College of Obstetricians and Gynecologists' (ACOG) official statement of policy regarding home birth reads: "Labor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation."

This suggests any board-certified physician providing supervision to a midwife who performs home births would violate professional standards.

"Home delivery is for pizza, not babies. I wouldn't want my daughter or someone I care about to have a home birth."

— Lawrence Bruksch, MD
Obstetrics/Gynecology
Los Angeles

A Collegial Relationship

To circumvent problems, some "midwife-friendly" physicians maintain collaborative relationships with licensed nurse-midwives that don't require direct supervision. But even these physicians are concerned that the arrange-

ment with a licensed midwife who performs home births might be construed as supervisory.

Dr. A., a West Los Angeles ob-gyn who prefers to remain anonymous, never set out to work with the home-birth movement. His original approach to obstetric care was naturalistic.

"I've always had a philosophy of letting the process of labor and birth go as nature intended, as long as we pay attention to safety issues," he says.

When patients who share this philosophy gravitated toward him, midwives who assist in home deliveries soon approached him about collaboration.

Why did Dr. A. accept this controversial challenge?

"I feel the midwives need a backup, and by law they need a backup," he says. When a woman who chooses home delivery sees Dr. A. as her "backup" physician only, he will sit down and talk to her about all of the potential hazards.

"It's not my responsibility to talk her out of home birth," he says, "because that would be unfair to the midwives involved."

Stringent Guidelines

The California Business and Professions Code related to midwifery limits licensed midwives' practices to "normal births" and compels them to refer all complications to a physician. The midwives Dr. A. covers for adhere to very strict guidelines concerning which patients are reasonable candidates for home birth.

"Even if a patient might balk at the idea of going to the hospital, by adhering to those guidelines you avoid getting in trouble," he says. "For example, we don't let anyone who's under 36 weeks deliver at home, even if she's one day shy of 36 weeks."

These midwives also will not deliver twins, breech births, vaginal births after cesareans or any other circumstances Dr. A. considers unsafe, and they present women with a long informed consent form that explains all potential risks of a home birth.

The Uncertainty of Birthing

While Dr. A. supports home birth and midwifery, he admits "the problem with home birthing is the uncertainty of birthing in general. You never know for sure, despite all the precautions in terms of triaging out patients who don't seem appropriate, whether something unplanned would happen and that the patient would be better off in the hospital."

When Los Angeles ob-gyn Mark Dwight, MD—who has a "hands off, noninterventionist" philosophy regarding childbirth—is approached by women interested in home birth, he uses a "car seat" metaphor to explain why he'd rather they deliver in the hospital.

"More than likely, you won't get in a car accident when you drive across town," he says, "but you still put your baby in a car seat."

Ideally, Dr. A. would like to see a woman have her baby in the hospital, but in one that encourages a more natural approach to the process.

"I believe hospitals have not been re-

Nomenclature

Types of Midwives

Certified nurse-midwife (CNM) One educated in the disciplines of both nursing and midwifery who is certified by the American College of Nurse-Midwives.*

Certified midwife (CM) One educated in the discipline of midwifery (but not nursing) who is certified by the American College of Nurse-Midwives. There is only one accredited program in the country that educates and prepares non-nurses for certification in midwifery. A prerequisite for this program is core competency in nursing education at the collegiate level.*

Certified professional midwife (CPM) One who has been certified by The Certified Professional Midwife program, created by the North American Registry of Midwives and two other midwifery groups to promote the profession.**

Licensed midwife (LM) One licensed to practice midwifery, usually in a home-birth setting. Educational, examination and clinical experience requirements for licensing are outlined in California's Business and Professions Code, Section 2505-2521.**

Lay midwife An uncertified or unlicensed midwife who delivers infants in a home setting. Also referred to as an independent, traditional, community, empirical or domiciliary midwife.

Direct entry midwife Any midwife who is not a nurse, who enters the vocation of midwifery directly. This term can be confusing, as it may be used to describe licensed midwives, lay midwives and certified professional midwives, as well as certified midwives.

**Recognized titles by the American Medical Association. While CMs and CNMs typically work in a clinical setting, a small percentage assist deliveries in a home setting.*

***Not recognized titles by the AMA. Typically, CPMs and LMs assist deliveries in a home setting.*

—L.D.

sponsive to patients' desires to keep more control of how things work regarding the nonessential aspects of birthing," he says. "People feel like the medical community in general is against their efforts to have a natural experience that isn't interrupted by a lot of unnecessary procedure."

But today's hospitals can offer a more home-like atmosphere and better birthing experience than many women imagine, according to Joan Hall, legislative advocate for ACOG's California District.

"In hospital maternity wards, they're looking at how to enhance the birthing experience while maintaining high standards of care for the mother and infant," she says.

Transfer of Care

Midwives who assist at home births are required by law to tell their clients—both verbally and in writing—the specific arrangements for transfer of care to a physician or hospital if complications arise.

According to Dr. A., a typical transfer of care applies when a woman has been in labor for too long or whose water breaks but isn't in labor.

"The midwife will call us, and we'll arrange to have the patient transferred to our facility," he says.

Emergencies, however, are another situation.

"One of the things I make patients aware of, when I'm the backup doctor, is that they're essentially under the midwife's care and decision-making," says Dr. A. "I participate only secondarily in those decisions. For example, if a woman experiences a postpartum hemorrhage and doesn't live close enough to her hospital, she'll have to go to the nearest emergency facility."

It's exactly this kind of situation that makes home-birth opponents nervous.

"When things go bad, they can go bad very quickly," Hall says. "If you are at home, a woman starts to hemor-

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Delivering the Goods

University of Philadelphia archaeologist Josef Wegner

William F. Steinmetz/Philadelphia Inquirer (KRT)

Ancient Egyptian Use of Birth Bricks Proved

By Aparna Surendran

A little over a year ago, deep in the bowels of a huge excavation site 300 miles south of Cairo, Josef Wegner turned over and over in his hands a brick encrusted with mud.

He knew it was made around 1700 B.C.; everything there was. He also guessed it might have some significance. Two years earlier, the University of Pennsylvania archaeologist had determined that the house where the object was later found had belonged to a nobleman.

But what was it?

A few hours later, after some careful work with a brush, a scene of a blue-haired mother and baby flanked by deities with the heads of cows slowly emerged from the dirt, and Wegner knew instantly what he had discovered. It was a birth brick—the first actual example of what previously had been known only from ancient drawings of birth scenes.

A woman—probably Renseneb, the daughter of a king and believed to be the wife of the nobleman—had likely squatted on this very brick to have a baby. The deities, still visible on several sides, would have protected mother and child.

"I was jumping around," says Wegner. "I knew it was a magical brick."

To an archaeologist like Wegner, an expert on Egypt's Middle Kingdom (2050 to 1650 B.C.) and associate curator in the Egyptian section of the University of Pennsylvania Museum of Archaeology and Anthropology, the symbolism, location, materials and surroundings of any given find provide a wealth of information about ancient society and culture, and sometimes even about an individual.

The birth brick—presumably one of a pair on which a woman squatted, with one foot on each as she pushed the baby out—was a mixture of mud from the Nile (about 9 miles away), straw and water. Lower-class workmen would knead a mixture like this with their feet and place it in a mold, a wooden block shaped like a brick without a top and bottom, says Emily Teeter, curator of Egyptian Antiquities at the University of Chicago.

The bricks then baked in the sun, says Teeter, who was not involved with Wegner's expedition. Skilled craftsmen would draw the scenes with paint made from ground min-

rhage, and you're 50 miles from the hospital, there's a good chance she could bleed out and die before she makes it to the hospital."

But Sparrevohn contends that when a woman delivers under the care of a midwife at home, her labor progression is monitored more intensely, so a potential problem can be discovered before it becomes serious.

"We're watching the woman every step of the way," she says, "and when you do that, you notice problems much earlier on."

Sparrevohn also points out that hospital deliveries cannot guarantee a good outcome.

"It's sad when it happens," she says, "but things go wrong in births. Not all babies live. We need to back away from convincing the public that if something goes wrong, it's someone's fault."

"Things go wrong in births. Not all babies live."

But the majority of ob-gyns aren't about to change their position on home birth anytime soon. For that matter, neither are the midwives who attend home births.

Ultimately, the two groups have the same goal: to ensure a positive outcome for both mother and baby. Fortunately, it's a goal they usually achieve—and occasionally by collaboration.

Laurel DiGangi is a Santa Clarita-based freelance writer and regular contributor to Southern California Physician. *She last wrote about whether acupuncturists should be allowed to perform comprehensive disability exams in the December issue.*

Wake-Up Call

Teen drug use

Overall, illegal drug use among U.S. teens in grades 7 through 12 is holding steady. The only exception is the use of ecstasy.

Overall

Percent of teens who say they have ever tried drugs*

'96	49%
'97	53%
'98	51%
'99	48%
'00	48%
'01	48%

*Includes marijuana, crack/cocaine, LSD, ecstasy, heroin, inhalants, methamphetamine

Ecstasy

Teens who say they have ever tried ecstasy

'96	7%
'97	7%
'98	7%
'99	7%
'00	10%
'01	12%

Legal drugs

Teens in 2001 who say they have:

Used alcohol in past year	53%
Smoked cigarettes in past month	28%

Drugs compared

Teens in 2001 who say they have ever tried:

Marijuana	41%
Inhalants	18%
Ecstasy	12%
Methamphetamine	11%
LSD	10%
Cocaine/crack	9%
Heroin	4%

Source: Partnership for a Drug-Free America survey of 6,937 teens, May-June 2001, 1.8% error margin, KRT Photo Service
Graphic: Judy Treible, Todd Lindeman

Without a Clue

By Ellen Creager

Parents see ecstasy as a fairly exotic, hard-to-get drug that their children almost certainly never have tried.

But teens see ecstasy as a fairly common, easy-to-get drug—and 12% say they have tried it.

This disconnect should be a wake-up call for parents, drug experts say.

"Teenagers I talk to keep telling me their parents don't have a clue," says Ken Krygel, a former police officer who specializes in tracking drug trends in the Detroit area. "Ecstasy is in school, in the Goth movement, at parties."

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The Detroit Free Press/KRT