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Annotation

The place of birth

One of the ill effects of the reorganisation of the National Health Service (NHS), among some good ones, was to confuse the nature of our obligations as physicians by merging the public with the private health services, with the result that we do not always realise in a particular transaction whether our prime responsibility is to our patient—that is, the child; our clients—that is, his or her parents; our paymaster—that is, the NHS; our peers, represented by the General Medical Council; the law, with which we usually deal through the medical defence societies; the community, working administratively through the community health councils; even sometimes our professional 'union', the British Medical Association; or properly subsuming all of them, our own personal and professional integrity. This confusion has had particularly sad results in relation to the maternity service, in that decisions about what is essentially a private assertion of fitness to reproduce have been pre-empted by a public concern about the statistics by which our reproductive efficiency as a nation is rightly or wrongly measured and assessed. Morbidity rates might be a better guide; for the preservation of a badly handicapped baby is a mixed blessing for the baby, his family, and the community; and half of the present mortality is in babies with congenital defects and at least 20% in babies at the limits of viability.

It is in this context that we need to pose the essentially ethical question of whether, in an overpopulated world, now coming to the end of its easily exploited resources, freedom to reproduce should be regarded as an absolute right; or whether, if the State is expected to mitigate the effects of natural selection on perinatal mortality and morbidity, it should exercise some form of community birth control in order to ensure that congenital handicap is reduced to a minimum. That the State has an interest there can be no doubt, not only because we all have to live with other people's children, but because we have come, now that we are all to some extent socialists, to consider ourselves as our brother's children's keepers. Kipling, in his fable about Mowgli's upbringing in *The jungle book*, describes the moment of truth when his wolf mother has to present the wolf-child, with her litter, to the rest of the pack for approval, with the threat of death for the unfit; and Aristotle in his politics is quite explicit about the elimination of unhealthy babies at birth (and the unwanted before birth).

> 'As to the exposure of children, let there be a law that no deformed child shall live. However, let no child be exposed because of excess population, but when couples have too many children, let abortions be procurred before sense and life have begun.'
>
> Aristotle. Politics.

As I see it, this is just another facet of the present profound political disagreement between those who see the State as an extended family and those who see it as a free association of those who have achieved maturity and independence as a result of good genes, good fortune, and a good upbringing. Perhaps those who demand a State-run health service are tacitly admitting the right of the State to determine what form that service should take, and what its priorities should be; in which case the individual will have to accept the kind of care that generates the best statistics. But in that case, the data should be carefully collected, meticulously analysed, and responsibly interpreted if they are not to lead to inappropriate decisions. In an argument of this kind, compromise is difficult to reach because, like Sidney Smith's Edinburgh wives quarrelling across an alley, the protagonists are arguing from different premises; one set of assumptions leading to eugenics as the other points back towards what is called social Darwinism. Perhaps we need to decide consciously what economic price we are prepared to pay for moral advantage and vice versa and not to assume, like Dr Pangloss, that whatever happens providence has so designed things that they will work towards the greatest good for the greatest number.

In the context of the maternity services, our present political stance has had two effects: the first, to elevate the physician's proper concern for safety into a mandate that governs the arrangement which he makes with his client for the conduct of pregnancy and birth: the second, to derive from ephemeral and fairly crude statistics empirical support for the *a priori* thesis that birth in hospital must be safer in all circumstances for mother and child. In fact, it might be truer to say that most

obstetricians feel safer in hospital: many mothers feel safer at home: and where babies are safer is still a matter of dispute; moreover this last question will always remain one because no general answer, applicable to all babies for all time in all parts of the country and every contingency, can be given, unless —as we are now doing—we actually so whittle down the domiciliary services, and so alienate the women who wish to use them and the professionals who wish to provide them, that they are made unsafe. What can no longer be taken for granted is that the statistics have demonstrated once and for all that hospital is safer than home; yet this is often the hidden premise on which discussion is based.

The evidence

As far as the admittedly out-of-date figures go, they would seem to indicate that:

(1) The safest and perhaps the most acceptable and economic policy in present conditions would be a 70/30% split between hospital and domiciliary birth.[1]

(2) That given adequate selection in the light of present standards and knowledge, low-risk women booked for home (or general practitioner unit) delivery will generate a lower perinatal mortality rate than similar women booked for hospital birth, even though mistakes in allocation continue to be made.[2–6]

(3) That the babies at greatest risk are low birthweight babies born at home though booked for hospital—that is babies born unexpectedly at home.[7] Other high risk groups are babies born to women who insist against advice on giving birth at home and subsequently require transfer to hospital.[8] Obviously sensible booking is essential; and it is apparent that more errors than need to be are made even in the light of present knowledge and that more research should be directed towards better prediction in the future.

(4) That arguments for the greater safety of hospital birth based on crude statistics are not acceptable and involve special pleading: it is true that hospital figures have in the past been weighted by high risk cases; but the same is true of home births in present circumstances. Moreover it appears that paediatric care of high quality is just as important, if not more important, than high quality obstetric care in reducing the risk to the class of low birthweight babies who generate most of the neonatal mortality not due to lethal and incorrigible congenital anomalies—that is, not every consultant unit is safer than a good home or general practitioner unit since, as the Short report has made clear, not every unit has adequate paediatric cover. If what is crucial is the intended place of birth at booking, the argument cuts both ways.[7 9]

The interpretation

Having shown, by what can only be called the abuse of our own statistics, that we cannot be trusted to know what is best for our clients, but only what is most reassuring, convenient, and satisfying for ourselves (and I couple neonatal paediatricians and obstetricians in this) we cannot complain if some of our clients drive too hard a bargain in the other direction; for we have left them no other way by which to assert their 'interest'. This will include considerations other than safety alone, pre-eminent though safety may and perhaps should be—such as, for instance, the importance for good practice of a good doctor getting to know his patients at the right level, at birth and death, and in their own setting, and for human beings of being born and dying (one hopes not both at once) at home.

But to return to the main argument about the place of birth; what is now needed is agreement that the available statistics do not give us the excuse to coerce women into consultant obstetric units for every birth nor on the other hand to coerce the professionals concerned (midwives, general practtioners, and consultants) into a domiciliary service which to make it safer for babies, and their mothers, might load them with intolerable burdens of work, responsibility, and anxiety. In Semmelwiesses day, obstetric hospitals were lethal for mothers, but since then we have at least contained, if not eliminàted completely, the menace of the group A β-haemolytic streptococcus (if only to see his brother the group B streptococcus step into his shoes) and it is now assumed that home is dangerous for babies because their lives may come to depend on the immediate application of high technology treatments. But though it may not at present be possible to foresee in the antenatal clinic the outcome of every pregnancy and labour, we are already fairly good at it; and to compel every woman to have her baby in a fully equipped and fully staffed unit, working at full throttle every night and every day of every week (and only such units would be safer than home) on the grounds that the minority within a minority in which the untoward may not have been foreseen, or foreseeable, might be safer there, is to pay an absurdly high price for a doubtful gain and one that may be more than counterbalanced by the very slight extra risk of hospital for the vast majority of women in whom things would go well at home. Thus it has been shown in Guatemala that personal care at birth greatly reduces the caesarean section rate.[12] Moreover, if we discount item by item, and in

proportion to their incidence and lethality for babies, those complications that are said to weight unfairly the perinatal mortality in hospital cases, birth at home still emerges as the safer overall option and that despite its own adverse weighting with unplanned or badly planned deliveries which fall on an increasingly inadequate service. Because of this weighting, birth at home is becoming statistically less safe than it was, while birth in hospital is getting apparently safer as the proportion of uncomplicated cases booked for hospital delivery rises with the availability of beds, the improving health of the population overall and the pressures on women to opt for birth in hospital.[4 10 11]

Future policies

The time has surely come to take another look at both sides of the question and to find a solution that is acceptable to all parties by reconciling reasonable standards of safety with emotional comfort and economy. This may involve recognising that booking for domiciliary birth may make consultant antenatal supervision mandatory; that the general practitioner's role in obstetrics may in future have to be that of covering the midwife by being prepared, equipped, trained, and present to resuscitate mother or baby should the need unexpectedly arise; that neonatal medicine should be included in the training of the general practitioner; and that the kind of maternity service provided for a given district, area or region, should be decided locally by a health care planning team on which mothers, midwives, general practitioners, obstetricians, and administrators should have equal voices.

In no part of the health service is there more need of what Wystan Auden epitomised as 'new styles or architecture and a change of HEART', if by architecture in this context we mean the structure of the service as well as of the hospital buildings. We shall not get one without the other; and without the competition of a community service, the maternity hospitals may never feel the need to change their attitudes. It is from those for whom everything has gone right from the beginning that we shall need to find our future leaders; and all the evidence goes to show that this depends on early social, emotional, and environmental as well as on physical and genetic factors.

Is there a lesson to be drawn from what has happened to our maternity services during the years since 1958? I believe that there are several. The first is not to meddle with plants that are healthy and growing well: that is, to leave a service that is functioning satisfactorily alone except to deal with particular problems, hang-ups, or abuses. The onus of proof should be on those who wish to change established things, not on those who wish to preserve them. Evolution is better for everybody than revolution; and revolution based on *a priori* ideas rarely does good, especially when these are derived from commissions and committees which are necessarily swayed by experts who so often represent the priorities of producers rather than consumers. So much for Peel and Cranbrook (although Cranbrook actually recommended only 70% hospital delivery). Reform is for the here and now in small things; for in the longer run conditions will have changed unforeseeably and we shall all be dead. Secondly, such changes as are made should not be made on the basis of inadequate, out of date, and to some extent misrepresented statistics of a general kind such as were extracted from the otherwise useful and helpful 1958 and 1970 perinatal mortality surveys: they are dangerous weapons in the hands of interested parties without professional training in their use and abuse. Moreover, conclusions that have been given life by statistics must be prepared to die by them. To base enforced change in an important part of the way of life of a nation on wrong figures is a kind of rape. Thirdly, birth, like war, is too important to be left to the experts on their own; the conscripts also have a right to be consulted. Finally we should never forget what has been achieved by well meaning, dedicated, and competent professionals in liberating nearly every family from the nightmare of losing its pivot—the mother—in childbirth, and for making it so much easier for babies to survive intact their sometimes traumatic entrance to the world. For as Tennyson said 'nature is only careful of the type' and professionals are there to mitigate her carelessness about the individual life. But medical care is personal or hardly worth having, and for families in their reproductive years its charity should perhaps begin at home.

The 1970 perinatal mortality survey could, if appropriately analysed, contribute new insights to the debate and one hopes that the custodians of the data will take up the challenge.

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