

I have recently (and rightly) been taken to task by a new mother about an article I wrote on home birth a number of years ago where I commented that the only women who were truly better off at home were those with chronic medical problems, such as insulin-dependent diabetes (IDDM) (Wickham 1999). I am delighted to publicly eat those words in the face of the experiences of a small number of women who have IDDM and who have also successfully given birth at home, including Elaine Lawson, who wrote about the birth of her son Ruben in AIMS' Journal (2000).

I don't think I have ever actually stated that women who were 44 weeks pregnant, group B strep positive, had placenta praevia, a footling breech or 13 previous births might not be ideal candidates for birthing at home, but if I had I would have to eat those words too - because I know of women in all of these circumstances who have recently chosen home births over the institutions and technology that was offered to them, who had happy and successful outcomes, and who would make the same choice again. One woman with diabetes who transferred into hospital (for a reason completely unrelated to having IDDM) told me she was still far happier with having been able to labour at home than she felt she would have been in hospital. It seems that there is a small but growing group of women who are refusing to obey the label of "high-risk" and who are instead becoming experts on their own specific health issues and making their own decisions based on their personal circumstances.

When we really think about the implications of the "high-risk" label, it is little wonder that women are challenging this concept. Women and their pregnancies may be labelled "high-risk" when the probability of an adverse outcome is greater than the average probability of an adverse outcome. Yet if we were applying this label accurately, healthy women who gave birth in hospital could be considered "high-risk" relative to healthy women who gave birth at home and healthy babies who were vaccinated could be considered "high-risk" compared to healthy babies who weren't vaccinated. If we were really concerned about reducing risk around childbirth, we would be doing less to prevent perfectly healthy women having home births, and more to eradicate poverty and sub-optimal nutrition.

Labelling a woman as "high risk" is really only helpful if we can actually do something to reduce the risk. All too often, we can't. What we can do, though, is to massively increase the level of anxiety a woman experiences during pregnancy and birth by applying our technologies and tests to assess the level of risk further. Indeed, we now have tens of screening tests, each of which can very effectively increase a woman's

anxiety and inhibit her ability to grow and birth her baby. If there were a prize for the society which created the greatest level of anxiety in pregnant and birthing women, ours would be a hot favourite.

In fact, prizes and outcomes are among the key issues in this area. People have completely different views on the outcomes that are important to them, on what they are willing to "risk" in order to achieve that outcome, and a personal comfort zone around risk-taking behaviour. You only have to watch a family play a board game which involves taking risks with money to see that some people are happy to bet all they have in the hope of gaining a big lead, while accepting the prospect that they might spend the rest of the evening watching from the sidelines, while others are very careful, hoping that prudence is the best tactic. These trends extend from the frivolous to the focal aspects of our lives, yet there is little application of the theory in this area to real-world health care practice.

None of the women I mentioned above took the risks of what they were doing lightly. Several of them made the choice to give birth at home in response to a lack of support from an institution for the kind of low-intervention experience they wanted. They all knew that the probability of a problem might be increased in their situation and thought long and hard before they made their choice. In becoming experts on the condition that they experience, some of these women realised that the suggestion that women with "risk" factors are better off giving birth in a hospital is often based on professional fear about what could go wrong rather than genuine evidence that this leads to better outcomes when everything is taken into account.

I feel it is quite unlikely that there are any plans for a research study to determine whether women with "risk" factors are better off giving birth at home or in a hospital. But, in the absence of quantitative data, we do at least have an age-old kind of evidence: women who have gone against the grain to provide us with living proof that we do not always know what is right for them.

References

Lawson, E (2000). Diabetic Birth Without the Drip AIMS Journal, Winter 2000/2001, 12(4): 10-12.

Wickham, S (1999). Home Birth - what are the issues? Midwifery Today, No 50, Summer 1999, pp 16-18.