SELECTION OF MOTHERS FOR HOME CONFINEMENT

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IN Great Britain between 20 and 30 out of every hundred babies are delivered at home or in small maternity units staffed by family doctors. Some method of selection for home delivery has been and must continue to be applied to the mothers of these babies. The standards of selection should be more clearly defined than at present. Obstetric teaching traditionally emphasizes the positive indications for delivery in hospital, and most previous advice on this subject has been given by obstetricians working only in hospitals. The factors which family-doctor obstetricians should take into account when a mother comes for consideration for domiciliary booking have received scant attention in the literature. It is clear that a home booking should neither be made simply if the accepted criteria for hospital booking are absent, nor purely in deference to the mother's wishes whilst disregarding obstetric factors.

The most recent list of criteria for domiciliary booking is stated on page 47 of *Confidential Inquiries into Maternal Deaths, 1958-60* (H.M.S.O. 1963):

1. As far as can be ascertained the woman's general physical state is unimpaired.
2. She is pregnant for the second, third or fourth time, the previous pregnancies, labours and puerperia have been normal and she is under 35 years of age.
3. She is a primigravida under 30 years of age.
4. She is rhesus positive, or is known to have no antibodies.
5. The home conditions are suitable.

The problem of risk to mother or baby when a home confinement is arranged is a difficult one. The *Perinatal Mortality Survey*, published in 1963, which covered all deliveries in a certain week in 1958, revealed an overall low mortality ratio for babies whose delivery was planned and completed at home. Marked increase in the ratio is evident for those originally booked at home or in a general-practitioner unit and later transferred to hospital care,

especially after labour had begun. The survey attributes the low mortality figures to careful selection of low-risk cases for home confinement, but later points out severe deficiencies in the standard of antenatal care outside hospital.

Some of the factors involved in domiciliary booking, as an aid to correct selection of patients will now be identified and discussed.

Agreement of parents

No woman should be forced by anybody to have her baby at home against her will. This leads to an unhappy and uncooperative mother. Similarly, if her husband absolutely refuses to allow his wife to have a baby at home, a hospital confinement should be arranged at the outset.

Facilities at home

If possible the mother should have her own room for delivery and ' lying-in '. This need not be large. It is impossible to accept a woman for home confinement for her second or third child if the whole family eats, sleeps, cooks and relaxes in one room. This is a common situation in cities and always a sound reason for hospital booking on so-called ' social grounds '. It is useful to have running hot water at a basin and if possible a fixed bath. Filling a tin bath with kettles in front of a fire is not the most satisfactory method of puerperal ablution, but very occasionally it has to be accepted. Domestic help, whether from within the family or from municipal sources is essential if the mother is to have mental as well as physical rest in the puerperium.

Agreement of doctor

To have her own family doctor attend her at a confinement is a great psychological asset to a mother and is frequently the start of a long professional relationship. He must be prepared to look after her carefully during her pregnancy with firm but kind discipline and to attend at her confinement. Unless he can do this with confidence and has his practice organized to this end he may as well not undertake domiciliary obstetrics. Attendance at a confinement should be obligatory and not merely at the urgent request of a midwife in difficulties. Much anxiety to all concerned is saved in this way. It is most important for the doctor to supervise carefully the third stage of labour, starting with the injection of an oxytocic drug whilst the midwife delivers the shoulders of the baby. It is reassuring if an obstetric ' flying squad ' is handy if urgently needed.

Obstetric considerations

Where the previous pregnancies have been straightforward in every respect there is no problem apart from that of parity. In the author's opinion only second and third babies should be delivered

at home. In certain circumstances first and fourth confinements should be considered. A primipara who is exceedingly keen on home confinement may be accepted if she has positive reasons for wanting to have her baby at home, and she is under 30 years of age. Naturally there must be a clear understanding that transfer to hospital care during pregnancy, should it be necessary, will be accepted without question. It is sometimes a wise step to let a consultant or registrar see a primipara at some time during the third trimester. He will then be acquainted with her should he be called on to help at any time. Multiparae in their fifth or subsequent pregnancies should never be accepted for home confinement, nor should any woman with a history of premature labour or premature infant born at or near term.

Other obstetric factors involve careful assessment of certain abnormalities in previous pregnancies and the likelihood of their recurrence.

1. *Abnormalities in previous pregnancies*

(*a*) Moderately excessive weight gain with or without mild toxaemia is common and tends to be repeated, but by no means always. It is not itself a bar to home booking at the outset if steps are taken to control weight in early pregnancy. Both weight gain and the blood pressure level must be regularly and carefully observed. Rest at home if advised should be seen to be strictly enforced. Reference to hospital is essential if the blood pressure rises above the locally accepted level, if albuminuria without pyuria is found, or if weight gain is uncontrollable. Mild toxaemia previously controlled with diet or diuretics is acceptable. Previous essential hypertension (high blood pressure in early pregnancy), and moderate or severe toxaemia are indications for hospital booking.

(*b*) Anaemia requires careful assessment. A patient with a history of anaemia in a previous pregnancy should have a full blood count performed when first seen, or if the haemoglobin level is 70 per cent or less in any patient seen at the first visit. Correct treatment is instituted from the start, and regular reliable blood counts done throughout pregnancy. In all cases the haemoglobin level must be repeated at or about the 32nd week of pregnancy or earlier if necessary. Ideally the haemoglobin level should be 75-80 per cent at the 36th week of pregnancy. Those women with a value lower than this should be referred for an opinion on the advisability of hospital delivery.

(*c*) Malpresentations: A previous baby may have been delivered as a breech possibly because it was diagnosed late in pregnancy, and thus not likely to recur. A history of unstable foetal lie in late pregnancy may well be repeated. This situation calls for hospital

booking. Similarly, mothers with a history of face, brow or shoulder presentation should be confined in hospital.

(*d*) Induction: The likelihood of repeated induction of labour depends on the reason for which it was done before. Postmaturity remains a problem which each of us must assess for ourselves, but a history of surgical induction for anything more than mild toxaemia is a contraindication to home booking. Some obstetric units have a high induction rate due to routine induction at 41 weeks gestation or for other questionable reasons. It is important to know if induction was performed in a previous labour, when, and for what precise indication.

2. *Previous confinements.* A clear history of the length of the stages of previous labours is of great value. It should be verified if necessary by obtaining a written record from the obstetrician concerned.

True inertia in any stage of labour tends to be recurrent especially in an overweight, sluggish woman. Consideration of prolonged second stage of labour is bound up with the question of previous assisted delivery. The indication for assisted delivery should always be carefully noted. There is a difference, in terms of likelihood of recurrence, between low forceps delivery after a longish second stage in a primigravida (length again dependent on local views), and a forceps rotation and delivery done for deep transverse arrest of the foetal head, possibly with a small but clinically unrecognizable degree of cavity or outlet contraction. The latter may well give rise to trouble in a subsequent labour, whilst the former is unlikely to happen again. Episiotomy performed for 'rigid perineum' is frequent in hospital delivery of primigravidae. Subsequent births are commonly accomplished without it unless the baby's head is unduly large.

Third stage abnormalities of any sort, having happened before, are an absolute bar to home confinement. They must always be regarded as potentially recurrent.

3. *Rhesus iso-immunization.* This is really a straightforward problem provided the patient's rhesus group, and sometimes her husband's, is known. For practical purposes, a rhesus negative woman pregnant for the second or third time with no history of antibody formation in a previous pregnancy may be confined at home if no antibodies are found in early pregnancy and again at 34 or 36 weeks. If antibodies are found during the current pregnancy and a home confinement has been arranged, she must be transferred for delivery to a unit adequately equipped to look after babies affected with haemolytic disease.

4. *Puerperia.* Careful inquiry must be made into a history of

previous pyrexia in the puerperium. Causes likely to be repeated are urinary infection and thrombophlebitis whilst a low fever from breast engorgement can be avoided by careful instruction in breast feeding, which is easily done at home.

Co-operation of the patient

It is a mistake in the long run to book for home delivery women of low intelligence and those who are intrinsically unreliable in their habits. Trouble during pregnancy and labour arises from failure to attend regularly and laxity in reporting untoward symptoms. Hospitals have to look after a number of this type of woman, who frequently become grande multiparae in the space of a few years, but their organization and perhaps authority seems to command more respect from people. There is no particular reason why this should be so. Each practitioner must have an efficient system for follow-up of defaulters from antenatal examinations.

Miscellaneous

A history of *congenital abnormality* is occasionally elicited. Although this may have been slight and theoretically non-recurrent, a patient who has had an abnormal baby will be happier with hospital care for a succeeding pregnancy.

A woman with a history of more than two previous *abortions* should be booked for hospital confinement, particularly if she has no living child. The perinatal mortality is said to be significantly higher in these women. However, a previous live birth followed by one abortion is a fairly common situation and is an acceptable proposition for home booking.

Conclusion

Successful obstetric practice involves a doctor in the art of intelligent anticipation more than any other branch of medicine. Nowhere is this maxim more important than in the field of domiciliary obstetrics where the responsibility of the doctor is so personal and complete.

Summary

Some of the criteria of suitability for booking for home confinement are examined and discussed. Stress is laid on extreme care in initial assessment, and the need for transfer to hospital care as soon as any untoward factor is suspected during pregnancy.

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