# An Analysis of the Changes in the American Management of Birth, 1955-1980

by

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Submitted in Partial Fulfillment

of the Requirements for the

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ABSTRACT

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The medical handling of childbirth in the United States has changed dramatically in the 25 years from 1955 to 1980 due to consumer demand. This seems to contradict conventional economic wisdom which suggests that medical markets are impervious to consumer pressure.

Several assumptions about medical markets do not hold in the market for obstetrical services. These include the amount of planning time and information available to consumers, the presence of competitive forces in the market, and the actions of consumer groups. Larger social movements have also had contributory effects.

Theories are suggested for predicting where change in medical markets may be expected to occur. Suggestions for medical regulation are offered. A proposal for certain changes in hospitals is offered.

Name of Thesis Supervisor: Lawrence Bacow
Title: Assistant Professor of
Urban Studies and Planning

obstetric: from Latin obstetrix, midwife, literally one who stands before (i.e. to receive the child), from ob, before, stare, to stand.
-- from Webster's Third International Dictionary Unabridged

The words "she", "her" and "hers" are used throughout this thesis in a generic sense, except where they refer to mothers or specific individual women.

TABLE OF CONTENTS


| | | |
|---|---|---|
| | Abstract | i |
| | Table of Contents | iii |
| | Acknowledgements | vi |
| | Preface | 1 |
| 1 | Introduction | 3 |
| 2 | Changes in Childbirth | 6 |
| 2.1 | Place of birth | 7 |
| 2.2 | Birth as a family affair | 9 |
| 2.3 | Anesthesia | 12 |
| 2.4 | Hospital procedures | 14 |
| 2.5 | Birthing rooms | 16 |
| 2.6 | Nurse-midwives | 17 |
| 2.7 | Breastfeeding | 19 |
| 2.8 | Rooming-in | 20 |
| 2.9 | Information and childbirth classes | 22 |
| 2.10 | Attitudes: mothers, doctors, and hospitals | 24 |
| 2.11 | Summary | 25 |
| 3 | The market for medical care | 26 |
| 3.1 | How the standard market works | 27 |
| 3.2 | How the market for medical care is different | 28 |
| 3.3 | Summary | 38 |

Table of Contents


| | | | |
|---|---|---|---|
| 4 | | Why did obstetrics change? | 38 |
| | 4.1 | Innate differences | 40 |
| | 4.2 | Competition | 42 |
| | 4.3 | Consumer groups | 47 |
| | 4.4 | Social movements | 50 |
| | 4.5 | Summary | 56 |
| 5 | | Conclusions | 57 |
| | 5.1 | Characteristics innate to obstetrics | 58 |
| | 5.2 | Non-innate factors affecting obstetrics today | 61 |
| | 5.3 | Essential factors for consumer choice | 63 |
| | 5.4 | Other medical markets | 66 |
| | 5.5 | Regulation | 69 |
| | 5.6 | Role for families and friends in the hospital | 72 |
| | 5.7 | Summary | 75 |


Appendices


| | | |
|---|---|---|
| A | Survey letter, questionnaire and data | 77 |
| B | Interviews | 91 |
| | Constance Bean | 91 |
| | Fred Frigoletto MD | 95 |
| | Fruma Ginsburgh MD | 97 |
| | Judy Luce | 100 |
| | Alice Roemer | 105 |

Table of Contents


| | | |
|---|---|---|
| B | Interviews (continued) | |
| | Mary Terrell . . . . . | 113 |
| C | Nurse-midwives in Massachusetts . . . . . | 119 |
| D | Information dissemination . . . . . | 120 |
| E | Proposal for a health education program . . . | 122 |
| F | Physician Accountability . . . . . | 126 |
| G | Patients' bill of rights . . . . . | 131 |
| | Bibliography . . . . . | 133 |
| | Biographical Notes . . . . . | 139 |

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# Preface

The management of birth in the United States is a complex issue. This thesis will only deal with a subsection of the issue, that of changes in hospital birth practices over the last twenty-five years. Twenty-five years is, by historical standards, an extremely short length of time. However, from a planning perspective, the changes in childbirth practices which have occurred in that length of time are very instructive. Historically speaking, planners seek to make changes that occur in a short period of time. My main emphasis will be on what I, the people I have interviewed, and many consumers view as positive changes.

I feel this is an appropriate focus for a planning thesis. Planning is about change, and how to effect positive change. This thesis, then, will examine a situation (childbirth practices) in which positive changes have taken place, consider how and why these changes came to pass, and try to learn from these how to effect similar changes in similar situations. Specifically, I will consider the question of how medical care in other areas can be made more responsive to consumers, using techniques suggested by the obstetrical example.

## Preface

My look at what some might call negative changes will be peripheral at best. It would, however, be unrealistic and perhaps a little dishonest not to include some mention of these changes and aspects of childbirth. Very briefly, these are:

1. The large amount of medical intervention in the birth process: induction of labor, fetal heart monitoring, routine hospital obstetrical preparatory procedures, routine hospital infant procedures, etc.
2. The rising rate of births by cesarean section in the United States.
3. The rate of complications during delivery.
4. The high infant mortality rate in the United States as compared with other industrialized nations.

Whether changes are positive or negative must always be a subjective or philosophical judgement. For this thesis, I will define positive changes to be those that are responsive to consumers: those that permit consumers more options and foster the knowledge to make choices between them. In an economic view, the the hospitals and physicians can be viewed as the marketplace, and the patients as their consumers. Positive changes, then, can be seen as corrections to market failures which prevent consumers from buying where their preferences lead them.

My definition of positive change would not be altered if this thesis were examined outside of an economic perspective. The true basis for my definition is a belief in individual freedoms and individual dignity, sharing of power, and a conviction that a good society is one in which individuals are given as much as possible in the way of both choices and protection of rights.

# Chapter 1: Introduction

Childbirth has changed dramatically in the United States in the last 25 years. There has been a revolution in the hospital management of birth. Women once went through birth essentially alone, delivered unconsciously under general anesthesia, and woke up groggy to be shown their babies, who were then whisked away to the nursery. Women were not given any choices in the process.

A woman giving birth today has a whole range of choices. She can give birth at home. If she chooses to give birth in a hospital, she can be attended by an obstetrician, a nurse-midwife or a family practitioner. She can have the father or another support person with her throughout the birth. She can give birth in a home-like birthing room, rather than go from labor room to delivery room. She has a range of analgesia and anesthesia from which to choose. She can choose to give birth without any drugs at all. She will find the hospital and her obstetrician far more solicitous than her mother did 25 years ago.

That this striking change has come about through comsumer

pressure is perhaps as amazing as the change itself. In economic theory, consumers are traditionally thought to be incapable of affecting medical care, because they are not felt to be capable of evaluating the services they purchase. Nevertheless, the changes that we see in birth today came about through persistence and hard work on the part of consumers. Consumers, both as individuals and as well-organized consumer groups, fought to gain control over the birth process and to make it more responsive to the needs of mothers and fathers.

In chapter two of this thesis, I will describe each of the changes in childbirth in detail. A survey I conducted of obstetrical units of varying sizes across the country documents these changes. Further understanding of the transformation in childbirth comes from interviews with people who have been directly involved with the process of change in birth.

Chapter three will present the traditional economic wisdom describing how the market for medical care is thought to differ from the market for other commodities. It will explain why consumers are thought not to be able to evaluate medical care, and hence why they cannot exert pressure in the medical market the way they can in other markets.

Chapter four will explain how and why the changes in childbirth have occurred. The people I interviewed shared some of their understanding of how and why these changes have come about. Chapter four will show why the market for obstetrical care differs from the medical market presented in chapter three. The effect of relevant social movements on the process of change in childbirth will be analyzed.

In chapter five, I will draw conclusions about the lessons to be learned from the changes in obstetrical practice, specifically where and under what conditions consumer pressure can be brought to bear in a medical market. I will then consider where else in medicine we might see, or as planners effect, changes similar to those in obstetrics.

# Chapter 2: Changes in Childbirth

As noted in the last chapter, there have been dramatic changes in how birth is managed and in the number and types of choices women have about the birth process. Each major aspect of birth management has undergone considerable change. In this chapter, I will discuss the changes individually and document them through a nationwide survey of hospitals, (1) through interviews, (2) and through the literature.

## 2.1 Place of birth

A woman giving birth today has the choice of giving birth at home, in a hospital, or, in some parts of the country, in an out-of-hospital birthing center. While this thesis is primarily concerned with increased choice in hospital birth, a brief mention of non-hospital choices is in order.

Out-of-hospital birthing centers offer an alternative to

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(1) See appendix A.

(2) See appendix B.

the hospital experience for many women. They are set up to be less hospital, more home-like. Little or no medical equipment is in view, and nurse-midwives are generally an integral part of the care provided. Birth in an out-of-hospital birthing center is less expensive than in a hospital.

Women giving birth at home usually want to retain control over the birth process and avoid technological interventions. The woman giving birth at home is in familiar surroundings, wearing her own clothing, and dealing with people she knows and has chosen to be present. Home births are often attended by lay midwives. (3) Home birth is much less expensive than hospital birth.

Many home birth advocates feel that by humanizing hospital birth, home birth and the need for home birth attendants and back-up emergency medical facilities will become a less immediate concern, and hence make home birth a less viable alternative.

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(3) The legal status of lay (i.e. unlicensed) midwives varies considerably from state to state.

## 2.2 Birth as a family affair

In 1955, most American women gave birth isolated from family and familiar supports. A woman in labor was with strangers whose faces changed every eight hours. Her obstetrician typically came in only for the birth, of which she was only dimly, if at all aware. The father was not expected to do more than take the woman in labor to the hospital, and then sit and worry. (4)

To many women, the change that has made the most difference has been having the father or another support person present with them during labor and delivery. By 1965, fathers in Massachusetts were allowed in labor rooms, but not in delivery rooms. In 1980, most hospitals allow fathers or other support persons in both labor and delivery rooms for normal vaginal deliveries as well as those with complications. Fathers are, in many hospitals, also allowed to be present for

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(4) In some parts of the country fathers were allowed to be present or could get permission to attend normal (i.e. no complications, non-cesarean section) deliveries. Even in these areas, however, very few parents were aware that there was an option of the father being present. Fruma Ginsburgh MD, Obstetrician-gynecologist, MIT Medical Department, interviewed April 15, 1980.

cesarean sections. This, however, is often restricted to elective cesarean sections, or those performed under local anesthesia.

Only one of the hospitals which responded to the survey allowed fathers to be present at deliveries in 1955. Fathers are now allowed to be present at all normal vaginal deliveries, and in most hospitals at those with complications. (5) While none of the hospitals resonding allowed fathers to be present at cesarean sections in 1955, over half now allow fathers to be present at cesarean sections performed under local anesthesia. One hospital also allows fathers to be present for cesarean sections done under general anesthesia. In approximately half the hospitals, fathers are actually present only 35-50% of the time. In the other half, fathers are present 75-95% of the time.

Some hospitals allow fathers to stay overnight with the mother and baby. In most places, fathers have extended visiting hours beyond regular hours. The mother's other children, who, in the past, were thought to harbor infection,

(5) One hospital does not allow fathers to be present at vaginal deliveries with complications. Another allows them to be present at forceps deliveries, but not if the woman is hemorrhaging.

are now permitted to visit her and their new sibling in the hospital. This often makes the birth of a baby less threatening to older siblings.

Only two hospitals reported extended visiting hours for fathers in 1955. None allowed sibling visits, that is, visits by a woman's other minor children, in 1955. In 1980, all hospitals report extended visiting hours for fathers. Two even have facilities for fathers to stay overnight. Now, too, over eighty percent of the hospitals allow sibling visits.

The effect of allowing the family more access to the hospital has been to make birth more family-centered. The woman giving birth is no longer alone. She has familiar people around to give her support and comfort, and to act as her advocates. The father is no longer left out. Once not part of the birth process at all, now has a role in childbirth. He no longer waits helplessly for many hours in a waiting room until the obstetrician comes out and says, "It's a girl." Fathers now see their babies born and participate in the process. As Connie Bean points out, "Good births are a good experience for women, and for men." (6)

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(6) Constance Bean, Patient Advocate, MIT Medical Department, interviewed March 10, 1980.

## 2.3 Anesthesia

"Birth used to be a very mysterious process that women went through in a medicated stupor, from which they emerged hours or days later." (7) While there was regional variation, (8) women in many parts of the country were given general anesthesia routinely. In all the hospitals surveyed, the proportion of patients receiving general anesthesia has gone down. There is, however, a wide regional variation. For 1955, three hospitals report a general anesthesia rate of from 90-98%, three other hospitals report that none was used. All the hospitals estimate that women in labor are receiving a lower level of barbiturates now than in 1965.

In many areas, scopolamine and other amnesiacs were also administered routinely. The 1950 edition of Williams Obstetrics devotes four pages to "programs designed to promote

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(7) Alice Roemer, Clinic Director for Maternal and Child Health, Mount Auburn Hospital, Cambridge, Massachusetts, interviewed April 23, 1980.

(8) While general anesthesia and scopolamine were used extensively in Boston in 1955, they were used much less frequently in Philadelphia at the same time. Fruma Ginsburgh interview, April 15, 1980.

amnesia".

> Under any of the amnesic programs, when successful, the patient usually sleeps quietly between pains but may exhibit varying degrees of restlessness during contractions; not infrequently she may shriek, make grimaces, and show other evidence of pain, but upon awakening from the narcosis, will remember little or nothing about her labor and will vow that she experienced no discomfort whatsoever. (9)

The 1966 edition of Synopsis of Obstetrics still mentions scopolamine "for analgesia and amnesia". (10)

After general anesthesia ceased to be an acceptable anaesthetic for obstetrics, spinal anesthesia combined with seconal (or demerol) began to be used. While not a general anaesthetic, this would cause women to be very hazy or asleep during most of the labor process. In 1970, Dr. T. Berry Brazelton published a study (11) of the effects on infants whose mothers were given seconal during labor and delivery. He showed adverse effects on weight gain, sucking ability, and mother-infant bonding.

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(9) Eastman, Nicholson J., Williams Obstetrics, Appleton-Century-Crofts, Inc., New York, 1950.

(10) McLennan, Charles E., Synopsis of Obstetrics, Mosby, St. Louis, 1966.

(11) Brazelton, T. Berry, "Infant outcome in Obstetric Anesthesia", ICEA News, Nov-Dec 1970, pp3-7.

Women in labor are still given barbiturates, but in smaller quantities than before. They are usually awake, and given spinal or epidural anaesthetics. Women are now usually allowed more choice as to what level of anesthesia they want. General anesthesia is no longer used much, except occasionally for cesarean section. Women today are usually asked by their obstetricians to what degree they wish to be anaesthetized, and at which point in labor. Women today have much more control over the type and amount of anesthesia they receive during birth than their mothers did 25 years ago.

Women being awake during birth was the first big step forward for them as consumers. Once women could see what was going on and hear what was being said by the medical staff around them, they could start learning about and addressing other issues in obstetrics.

## 2.4 Hospital procedures

Many hospitals no longer require a prep (12) and enema.

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(12) Shaving of the vulval area.

Mothers can request LeBoyer baths, delayed cord cutting, and delayed silver nitrate drops.

A LeBoyer bath is a body-temperature bath that the baby is put into just after birth. LeBoyer theorized that it must be a shock for the infant to go from a warm, dark, fluid-filled uterus to a colder, dry, brightly lit, noisy hospital room. The warm fluid sensation is felt to be a reassuring and womb-like experience for the baby. (13)

Even after the baby is born, the baby continues to be connected to the placenta and its blood supply through the umbilical cord for a short time. This continues to supply the baby with oxygenated blood. If the cord is not cut immediately, the baby has more time after birth before it must start breathing for itself.

In Massachusetts and other states, hospitals are required by law to put silver nitrate drops into the eyes of all hospital-born infants. This prevents the blindness that can occur if the mother is infected with gonorrhea. Silver nitrate blocks the baby's ability to see for several days. Delayed

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(13) Trotter, R.J., "Changing the Face of Birth", Science News 108:106-8, August 16, 1975.

silver nitrate drops give babies a chance to see their new world at birth.

## 2.5 Birthing rooms

The original reason for the division of labor and delivery rooms was because of a mistaken belief that this would help prevent infection. Later, the division became necessary because women delivering under general anesthesia had to be strapped down. There are now birthing rooms in which a woman can both labor and give birth in one room. Even women who do not give birth in birthing rooms are moved from room to room less than previously. (14)

Birthing rooms allow for labor and delivery in a setting which is less mechanized and medical medical with a more home-like atmosphere. Birthing rooms usually look very similar to regular bedrooms. There are colorful curtains on the windows, carpeting on the floor, a bedspread on the bed, and an armchair or two in the room. The father, and sometimes other family members or friends are present.

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(14) Connie Bean, interviewed March 10, 1980.

Just over one third of the hospitals responding to the survey have or are opening birthing rooms. One is in the process of establishing an out-of-hospital birthing center to open this year. Given how recently most of the birthing rooms opened (three-fourths have opened or will open this year), I suspect that this is a trend that is just developing.

## 2.6 Nurse-midwives

Nurse-midwives are now permitted to practice in hospitals in many (but not all) states. (15) Massachusetts legalized nurse-midwifery in hospitals in 1977. (16) Nurse-midwives are nurses who have completed a post-RN or Master's degree level of training in obstetrics, and who are certified by the American College of Nurse-Midwives. Nurse-midwives may deal either with home or hospital births, although the tendency (and, in some places, the legal restriction) is to deal with hospital births as part of an obstetrical team. Some nurse-midwives attend births in poor, rural areas that cannot support physicians.

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(15) Hotchner, Tracy, Pregnancy and Childbirth, Avon, New York, NY, 1979, page 219.

(16) Chapter 129, acts of 1977, Massachusetts General Laws.

There are only fifteen schools offering nurse-midwifery programs in the United States. (17)

An important difference between doctor and midwife is that the midwife stays with the mother throughout labor and delivery, and several hours past delivery. The midwife's focus is on the mother's progress, unlike that of the doctor, who may attempt to fit the mother into her schedule. The obstetrician will, in general, come in for the delivery, but will spend little time with the mother either before or after the birth. Because nurse-midwives spend more time with the patient, they are usually more flexible. They usually let the mother to choose her own position for giving birth, and can give the time necessary to massage the perineum, and thereby prevent the necessity for an episiotomy. (18) For many mothers, it is the constant attention of one familiar person, the constant reassurance, and the ongoing explanation of what is happening and why, that makes midwives so different, and preferrable to

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(17) The Nurse-Midwife -- A Member of the Modern Obstetric Team, by the American College of Nurse-Midwives.

(18) An episiotomy is a cut made in the perineum to make the vaginal opening wider and allow more room for the baby's head. An episiotomy prevents the tearing of tissue that occasionally occurs.

physicians. (19) As Alice Roemer explains, "Nurse-midwives will put themselves out for you, but not doctors". (20) The number of nurse-midwives practicing in the greater Boston metropolitan area is small, 17 in 1978. (21) Only two of the hospitals surveyed have nurse-midwives practicing in them, although three-fourths are in areas that allow nurse-midwives to practice. Another hospital permitted nurse-midwives to practice in 1955, although it no longer does so. On the basis of the survey and the Massachusetts statistics, it seems that nurse-midwives still have a long way to go before they are generally accepted in hospitals.

## 2.7 Breastfeeding

In the past, women were deterred from breastfeeding their infants. Bottle feeding was considered to be more modern and fashionable. Physicians discouraged breastfeeding. Now, there

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(19) Nicholson, Marjorie E., "Maternity Care as Perceived by Newly-Delivered Mothers under the Care of Nurse-Midwives and Those

(20) Alice Roemer, interviewed April 23, 1980.

(21) See Appendix C.

is encouragement and acceptance for breastfeeding from physicians and hospital staff. Postpartum breastfeeding classes are held in hospitals, and breastfeeding is covered in prenatal childbirth classes.

As with other changes in childbirth, breastfeeding shows regional variation. Dr. Ginsburgh reports that breastfeeding was popular in Philadelphia in 1955. (22) Nearly three-fourths of the hospitals responding to the survey, however, report an increase in breastfeeding since 1955. One hospital reports a decrease, and the rest (over 20%) say that there has been no change.

## 2.8 Rooming-in

In the past, the mother was (and, in many places, still is) shown her baby briefly before it was taken away to be weighed, examined, and sent off to the nursery. Babies would be brought up to mothers in their rooms on a regular schedule. Mothers who wanted to breastfeed could not demand feed. (23)

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(22) Fruma Ginsburgh, interviewed April 15 1980.

(23) Demand feeding is feeding the baby "on demand" i.e. when she cries and is hungry.

If their babies were hungry and cried in the nursery, the nurses would feed them sugar water. If babies were not hungry at the scheduled visits with their mothers (because of the sugar water), the mother would have difficulty establishing her milk supply.

Rooming-in programs, under which the baby stays with the mother in her room after the birth, are now common options. With one exception, all the hospitals surveyed have rooming-in. In 30% of the hospitals, rooming-in is for all babies; in the remaining hospitals rooming-in is available by request. None of the hospitals had rooming-in in 1955.

Rooming-in is important because there is increasing evidence that a vital psychological bonding process takes place between mother and child in the first few hours of a child's life. In one study, mothers were placed into two groups. The first group got a glimpse of their babies at birth, contact after six to twelve hours, and half-hour visits every four hours for bottle feedings. The second group was allowed one hour's contact with the baby within three hours after delivery, and an extra five hours every afternoon, a total of sixteen extra hours. A month later, the mothers were assessed on various aspects of how much attention they gave their babies.

The extra-contact mothers scored significantly higher in all cases. These differences were noticeable as much as three years after birth. (24)

In recognition of the importance of parent-baby contact, some hospitals have established special-care nurseries which allow 24-hour visits by parents, thus effectively abolishing feeding schedules. A special nurse is assigned to each infant to assure a degree of continuity of care. (25)

## 2.9 Information and childbirth classes

Women giving birth today have access to much more information than their mothers did in 1955. A major source of information is childbirth classes. All but one of the hospitals responding to the survey now offer childbirth classes. (26)

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(24) Klaus, Marshall H, et al., "Maternal Attachment: Importance of the First Post-Partum Days", New England Journal of Medicine 286(9):460-3, March 2, 1972.

(25) Alice Roemer, interview April 23, 1980.

(26) The hospital that does not offer classes reports that they are available in the community.

Childbirth classes differ. Hospital classes prepare couples for birth in a hospital. Homebirth groups give classes that prepare mothers to give birth at home. Some classes teach breathing and exercises to deal with pain in labor, most popularly the Lamaze method. (27) Classes encourage women to breastfeed, and to better understand and tolerate the pain of delivery.

Books on childbirth abound. Some are books which prepare women for childbirth; some have biological information about birth; some are analyses and critiques; some are strongly in favor of homebirths; some are not. There are many books, and they are written from many perspectives. Twenty-five years ago, few books were available; none had wide readership.

This increase in information allows for more educated consumers than in the past, consumers who are better able to make choices.

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(27) Karmel, Marjorie, Thank you, Dr. Lamaze: A Mother's Experiences in Painless Childbirth, Doubleday & Co., Inc. New York, 1965.

## 2.10 Attitudes: mothers, doctors, and hospitals

All of the people I interviewed mentioned a change in women's attitudes toward birth. Dr. Fred Frigoletto says that patients today are less afraid of childbirth than patients twenty-five years ago. (28) Alice Roemer points to a diminished degree of blind faith on the part of consumers in the members of the medical community. (29) Judy Luce asserts that women now have more confidence in their bodies' ability to give birth unaided. She sees parents' taking more responsibility for birth as a healthy phenomenon. (30)

Physicians are now much more solicitous of patients, and give them many more choices. Dr. Ginsburgh says that formerly women were assumed to know very little, and that there was no point in telling them anything, a view that she characterizes as reactionary and provincial. She says that such attitudes have changed. (31)

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(28) Fred Frigoletto MD, Chief of Processional Services, Boston Hospital for Women, telephone interview, April 30, 1980.

(29) Alice Roemer, interviewed April 23, 1980.

(30) Judy Luce, Lay midwife, interviewed April 18, 1980.

(31) Fruma Ginsburgh, interviewed April 15, 1980.

Mary Terrell sees many changes in the hospital birth experience since her first child's birth. At that time, she says, she "had to fight for everything". She was discouraged from breastfeeding her child, her husband could not participate in the birth, she had to insist on getting information from doctors and nurses. It was difficult to for her get the natural childbirth she wanted. (32)

Hospitals now have much more flexible rules. The staff is more accommodating. Attitudes have changed. Hospitals advertise their birthing rooms, childbirth classes, and family-centered births. Some hospitals even have candlelight or champagne dinners for new parents. (33)

## 2.11 Summary

There has been a significant change in the management of hospital birth. Families have much more control over the birth

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(32) Mary Terrell, Health Planner, Abt Associates, Cambridge, Massachusetts, former Planner for the Massachusetts Department of Pubic Health, interviewed April 28, 1980.

(33) Connie Bean, interviewed March 10, 1980.

process in hospitals than they did twenty-five years ago. Physicians and hospitals are much more accommodating than they once were.

There have been many consumer-oriented changes, as substantiated by the survey. They include the presence of the father or a support person at delivery, the change from general to local anesthesia, and the lowered level of the latter. The introduction of nurse-midwives, birthing rooms, and rooming-in have all made hospital birth more acceptable to mothers and families. Flexibility in hospital procedures, encouragement to breastfeed, and sibling visits have also contributed to an improvement in the hospital experience.

# Chapter 3: The market for medical care

In the last chapter, we saw how dramatically the handling of childbirth has changed in resonse to consumer pressure. In this chapter, we will show how the market for medical care is thought to be different from standard markets, and why the consumer is not thought to be able to influence the marketplace through preference and choice.

## 3.1 How the standard market works

A well-functioning market has strong competitive forces. Consumer preferences and tastes determine which merchants will survive. For example, in the restaurant business, if people like a restaurant and continue to return, it flourishes. If people don't like it and don't eat there, it folds.

But, how do you decide which restaurant you will eat at? You see an advertisement in the newspaper; on the next page is a review of the restaurant. It won an award. Your best friend recommended it, saying it was the best food she had ever eaten. You go to the restaurant, and look at the menu and the prices.

You feel like having French food tonight, and the prices are about what you expected to pay. You see that although it is early, a line is already forming, indicating to you that many people think it is good. You try it out. If you like it, you will be back again; if not, you won't.

## 3.2 How the market for medical care is different

The market for medical care is very different from that of restaurants, particularly regarding consumer choice and competition. The consumer is not thought to have the ability to make decisions, and hence choices. Her access to information is limited, and the nature of the supply is very different.

Medical consumers don't know what they want: For example, if a woman goes to her doctor with a lump in her breast, the physician tells the patient that her breast needs to be removed, usually within the week. Contrast this situation with your ability to decide you wish to eat at a Chinese restaurant tonight.

The average medical consumer is at an enormous

disadvantage with regard to information about both what she needs and what she is buying. The patient as consumer relies on the physician as merchant to tell her what she needs.

Medical information is difficult for the consumer to gather on her own. It is usually hard to locate, difficult and time-consuming to understand, and expensive. In fact, the value of the information is frequently not known to the patient-consumer. If the consumer were able to measure the value of the information, she would already know it. For example, in an office visit for a sore throat, you may be told that you have a cold. On the other hand, you may be told that you have cancer. The visit costs the same, but the value of the information to the patient is quite different.

In industry, there is always inequality of information between producer and consumer. Usually, however, the consumer, unlike the patient, knows the utility of a product as well as the producer.

Medical consumers don't know how much they want: Your physician decides on a radical, modified, or partial mastectomy. You decide you want what you want from the menu and the price list.

Consumers rely on physicians for information and services, both of which are commodities. Physicians, therefore, affect both supply and demand. This leads to a potential conflict of interest, which may result in overconsumption. The consumer does not, and cannot, make an independent choice about what services she wants, and the physician has a financial and legal (1) interest in providing information which leads to consumption of services.

Medical consumers don't know how to evaluate what they have received: The patient must also rely on the physician to tell her what has been bought, since she will ordinarily have no way of knowing whether the results she sees are a result of treatment or would have happened naturally (for example, it

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(1) The recent increase in malpractice suits has lead to a practice of defensive medicine. Defensive medicine, the practice of ordering extra tests and procedures so as to be covered in the event of a malpractice claim, is widespread. The costs of this practice to consumers either as individuals or as members of shared insurance plans is very large.

We have no mechanism which allows a patient-consumer to make her own choices and not hold the physician liable. We cannot have such a mechanism while the information gap between consumers and physicians remains. As long as patient-consumers are dependent on physicians for both information and services, the potential for abuse is too great for society to allow such a mechanism.

takes the doctor a week to cure your cold; otherwise, you get better in seven days.) Occasionally, results are not even noticeable, which makes them all the more difficult to judge (for example, immunizations). Often, consumers are not even sure what has been bought, because the physician's explanation is not clear or understandable. The inability of the consumer to judge the quality of goods is thought to lead to higher prices, as comparison shopping is severely hampered, if not impossible.

Medical consumers have no way to get information about the doctor or the hospital: There are no newpaper reviews, "best in the city" awards, no early waiting line, no menus, and rarely a price list for medical services. Also, it is likely that you don't know anyone who has needed exactly the same kind of procedure that you do. Even if you do, your friends cannot evaluate their medical care any more than you can. If you ask them whether the surgeon was any good, they can tell you that she had a good bedside manner and spent a lot of time with them after the surgery. They can't tell if the surgeon did a good job surgically, because they have no way to evaluate this. It's as if they went to a restruant and reported back about the service but couldn't tell you about the food. Traditional physician bans on advertising and taboos on criticism of fellow

physicians increase this information gap.

Medical consumers don't have time to plan: If your in-laws will be visiting in three weeks, you can check out several restaurants in advance to make sure all will go well. Contrast this with the situation where you need an emergency appendectomy, where your surgeon says your tumor must be removed within the week, or where you are miserably ill with an ear infection.

The consumer often has little time to obtain information about procedures. In an emergency situation where medical help is needed immediately, there is no time to plan or shop around. A few hours, or less, can sometimes mean the difference between life and death.

Even in a non-emergency situation, one can be miserably ill and dysfunctional. In this condition it is usually very difficult to do any more than get to a physician and go home again. One is usually interested in getting whatever help is needed to become well. The cost of gathering information is high because the priority is to get well again quickly, and because the longer one remains untreated, the higher the risk of developing complications.

For many non-elective surgical procedures, the patient feels well enough to spend the time gathering information or shopping around. Frequently, however, the patient is told that the required procedure must be performed immediately, or the patient will run the risk of becoming far more seriously ill. This is particularly true in the case of cancer. Thus, the patient is made to feel that there is no time in which to gather information.

Medical consumers can not learn through repetition: You have gall-bladder surgery -- once. You go back to a particular restaurant once a month, because it was good.

With most products and services, the consumer can learn from experience. In a serious illness situation, this is nearly never true. You will probably never go back to that service, in that hospital, with that specialist again.

Medical decisions are made at a time of trauma: Your physician tells you that your breast will have to be removed. Contrast this with deciding that you want to go to a moderately-priced Italian restaurant.

The stakes in buying medical care can be very high. No one can be expected to behave in an economically rational fashion when there is a question of permanent physical injury or death.

In the classic economic market, consumers are expected to make rational choices. Where life and health are at risk, people do not make choices in the same way that they do about buying more standard consumer goods. There is a societal belief that one should spend without regard to cost whenever medical problems arise. Contrast this with a restaurant situation, where consumer demand is very dependent on price.

How patients and physicians and buyers and sellers interact: As a patient, you want to trust your physician. You want to trust the person to whom you entrust your life and health. Physicians don't want to scare, upset, or worry their patients with discussions of risk, so they exercise discretion over the amount of information they tell any patient about her condition. This has led to a pattern of patients not asking their physicians for information, and physicians not telling.

Contrast this with the restaurant example. If you want information about an item on the menu, you ask and are told

about it. You don't particularly need to trust the restaurant. You can judge for yourself if the food was good. You can determine whether you get everything you order. Furthermore, the stakes are not very high: they could ruin your dinner, but not your life or heatlh.

The expected norms of behavior for physicians deviate markedly from those expected of the usual producer of goods or services in a market. While these norms make it possible for people to be trusting, they also remove the pressure for good performance that is sometimes created by the skeptical consumer. Physicians are expected to adhere to a particular code of ethics not required of other merchants.

- Physicians are not expected to advertise or compete with one another, a condition made possible by barriers to entry into the market.
- It is expected that the advice a physician gives to a patient will be entirely divorced from self-interest, and that recommended treatment will not be financially dictated. There is certainly evidence that physicians do not always adhere strictly to these requirements, (2) but the social expectation is present.

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(2) Corea, Gena, The Hidden Malpractice, Harcourt, Brace, Jovanovich, New York, 1977, p268.

- Physicians are considered experts for the purposes of certifying illness or injury for legal, work-related, insurance, and other purposes. It is expected that the physician's concern for giving correct information will outweigh any desire to please her patient-customers.

Hospitals don't compete for patients: You need your wisdom teeth removed. Your oral surgeon gets you a room, five weeks hence, at La Obscura Hospital, where she has admitting privileges. You don't like the food at La Beaux Delles Restaurante, so you go someplace else.

In the traditional view of the market, the pressure the consumer can bring to bear is known as demand. Demand is a function of the price of goods, income level, prices of competing or complementary goods, and other factors.

Health planners, in contrast, talk about need, rather than demand. Unlike demand, need is not dependent on the consumer's ability to pay, her access to medical care, nor, often, her preferences. An automobile consumer's demands are defined by her preferences; her medical needs are defined by her physician.

Hospitals do not compete for patients the way a restaurant competes for dinner-goers. Rather, hospitals compete for physicians' referrals. A physician may enjoy working in a teaching hospital, where reasearch is being conducted. In contrast to a community hospital, the teaching hospital is interesting, prestigious, and keeps her up-to-date. The patient, on the other hand, might prefer not to deal with medical students or researchers, but the patient goes where she is referred. The hospital's incentive is clearly to cater to the physicians, rather than the patient, because it is the physician who brings in the business.

Hospitals don't come and go: There are certain barriers to opening a restaurant. You need capital, a license (or licenses); you must find a location and advertise. Compare this, however, with what is needed to start a new hospital. A much larger amount of capital is required. The prospective hospital must apply for a Certificate of Need. Issuance is not certain, and can take a year or more. Many licenses, and many licensed personnel will also be necessary. It is easy to see why restaurants come and go, and hospitals don't.

Becoming a doctor is also not as easy as becoming a restauranteur. Entrance into the profession of medicine is

restricted by licensing of physicians, the restriction of entrance into medical school, and the cost, time, and demands of a medical education. Unlike restaurants, having a range of quality and price of medical care available is not considered acceptable by society. Everyone is entitled to "the best" medical care available. (In reality, of course, different people receive different qualities of care.)

## 3.3 Summary

Medical markets function differently from standard markets because consumers of medicine don't know what they want, nor how to evaluate what they get. They must rely on the physician to tell them. Patients have a vested interest in trusting their physicians. Medical consumers don't have access to information. They usually don't have much time to make decisions, and those decisions usually must be made at a traumatic time in their lives. Consumers usually cannot learn by experience, because most medical decisions are only made once. Hospitals do not cater to patients; they cater to physicians because it isphysicians who keep them in business. As a result, market forces do not work in the traditional manner, and government intervention or regulation is often

viewed as necessary to protect the interests of the consumer.

# Chapter 4: Why did obstetrics change?

The last chapter discussed why consumers are not able to affect medical markets. However, as we saw in Chapter 2, the market for obstetrical care has changed considerably. The first two sections of this chapter will examine the structure of the market for medical care and see how and why the standard assumptions about medical markets don't hold for the market for obstetrical care. The second two sections will examine the effects of childbirth organizations and other related consumer movements.

## 4.1 Innate differences

There are innate differences between obstetrics and other medical procedures. Birth, after all, is a normal function of the human body. It is not an illness nor, normally, a medical crisis.

Planning time: Obstetrics differs from most other medical procedures in that the knowledge that a birth will occur is always available several months in advance. Birth is an event

for which plans can be made. In an age of readily available birth control and abortion, plans can even be, and often are, made, by some, years in advance. Unlike emergency surgery or hospitalization, expectant parents can do some shopping around among doctors. They have time to ask friends and acquaintances about particular doctors and hospitals.

Birth is a common experience: Unlike gall bladder surgery, many people have children. Almost everyone knows many people who have gone through childbirth. Unlike gall bladder surgery, therefore, an obstetrical patient has many people from whom she can get information.

Repetition: Many people who have children have more than one. Thus, they can evaluate each birth procedure, and seek changes in the next one. To quote Connie Bean, "There is hardly anyone I know who hasn't learned something for the next time." (1) Through comparison, patient-consumers can begin to make judgements about medical care, independent of physicians. For example, women can change doctors or hospitals. They can (and do) insist on receiving fewer drugs, fewer medical interventions, having the father present, etc.

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(1) Connie Bean, interviewed March 10, 1980.

The non-traumatic nature of birth: Birth does not come as a traumatic medical event in most people's lives. Birth is almost never life threatening (although it once was), and rarely health-threatening. In contrast, consider the case of the heart attack or cancer patient. The non-traumatic, low-risk nature of childbirth is conducive to decision-making that is more like that in a non-medical market.

## 4.2 Competition

For a variety of reasons, there is keen competition for obstetrical patients. This diverges radically from the principle that physicians and hospitals do not compete in the way that merchants in standard markets compete.

Hospital competition: A critical factor affecting hospitals across the United States is decreasing occupancy. This has been particularly severe in obstetrical units, due to declining birth rates. There has been a move to close obstetric beds in hospitals with small obstetrical words, due to studies indicating that hospitals in which fewer deliveries were

performed were less safe (2) and less cost-effective. (3)

The only way for smaller obstetrical units to fight to keep their doors open has been through community support and community demand. They fight the needs assessments which often recommend closing small obstetrical wards by demonstrating the community demand for their services.

Hospitals began to notice that pregnant women did not just go to the hospital to which they had been referred. Connie Bean says that women went to the hospitals that allowed fathers into the delivery room. (4) In the words of one hospital administrator,

> "Our Ob-Gyn department was going to fold if it didn't respond to consumers' wishes for a home-like atmosphere and some control over deliveries . . . we were doing between 12 and 15 deliveries a month at the time. Now we're doing 70 to 80; and our active staff has about doubled." (5)

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(2) Klein, Michael C. et al, "Can Perinatal Regionalization be Reconciled with Family-Centered Maternal Care?", Journal of Family Practice 5(6):969-74, December 1977.

(3) Committee on Perinatal Health, Toward Improving the Outcome of Pregnancy, National Foundation-March of Dimes, 1976.

(4) Connie Bean, interviewed March 10, 1980.

(5) "Hospitals Bow to Couples Wanting Special Births: Chicago", Medical World News 18:38-9, October 3, 1977.

Smaller obstetric wards had a strong incentive to change obstetric practice in response to consumer demand, in order to draw clients away from larger hospitals. Larger hospitals, losing patients, were forced to compete. This allowed such changes as birthing rooms, increased openness to "natural" childbirth, childbirth classes, reduced use of barbiturates, rooming-in arrangements, the presence of the father throughout the birth process, and increased presence of nurse-midwives.

Hospitals now advertise their birthing rooms and family-centered births. This provides consumers with hitherto unavailable information about hospitals. For example, St. Margaret's Hospital in Boston placed an advertising supplement in the Boston Globe with descriptions and pictures of their birthing rooms. At a local health fair, Leaonard Morse Hospital in Natick, Massachusetts advertised, "Have Your Baby Your Way at Leonard Morse Hospital." As Dr. Frigoletto, head obstetrician at the Boston Hospital for Women said, "That's what sells." (6)

Competition with homebirth: In her interview, Alice Roemer

(6) Fred Frigoletto MD, interviewed April 30, 1980.

stated that the primary motivations for changes in hospital management of birth are related to the homebirth movement. In the 1960s, various consumer groups, communes, lay midwives and others began to question medical care in general, and began conducting births at home, and discovering that births at home work -- most women can give birth safely, with no lacerations or other harmful effects. These, along with other developments in women's health care brought about by the women's movement, taught women that their bodies "could do it", that is, that most women, could give birth relatively easily without the help or interference of medical personnel.

Ms. Roemed states that hospitals and doctors began to respond to consumer pressure in the face of the competition from home births and midwives. She suggested that there were three motivations for their response. First, there was the issue of lost revenue. Each birth attended by a midwife at home was one less for which a consumer paid a doctor and a hospital. Secondly, some doctors were genuinely concerned about the 5-10% of women who cannot give birth normally. These high-risk women, they felt, cannot always be screened out in advance, and thus all pregnant women would be safer if hospitalized. Finally, there are many doctors who were philosophically troubled by the notion of birth at home. In

Ms. Roemer's words, it reminds them of appendectomies on the kitchen table. (7)

Competition with physicians: Initially, obstetricians in many places were resistant to change in the ways they practiced birth. Several factors probably account for the changes in their behavior. First, the lower birth rate and rising consumer pressure affected obstetricians similarly to hospitals. Physicians were also under pressure from hospitals to try to increase their occupancy rates.

Nurse-midwives attracted some of the homebirth women back to the hospital. Mary Terrell quoted one obstetrician who, referring to the nurse-midwife he recently brought into his practice, said "she's worth her weight in gold." (8) With the declining birth rates, nurse-midwives, the homebirth movement, and, more recently, family practitioners are seen as competition by many obstetricians. They have had to change their practices in order to compete.

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(7) Alice Roemer, interviewed April 23, 1980.

(8) Masry Terrell, interviewed April 28, 1980.

Dr. Ginsburgh suggests that as younger obstetricians' wives became pregnant and went through birth in hospitals, their husbands became more sensitive to the problems of women going through childbirth. Older physicians had to change or lose their patients. Certainly, the increased number of women becoming physicians must have had its effects. Some physicians were willing to try change out of concern for the infant mortality rate in the Unisted States, as compared with other nations. (9) Other doctors felt that there was no harm in alternative ways of birth. Finally, some doctors went along with and worked for change because they felt strongly that it was right.

## 4.3 Consumer groups

When I asked my interviewees why hospital birth had changed, the first responses did not mention competition and consumer pressure. "Women were angry." (10) "Women wanted

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(9) The United States' infant mortality rate ranks 16th behind, in order, Sweden, the Netherlands, Finland, Japan, Norway, Denmark, France, Switzerland, New Zealand, Australia, Canada, United Kingdom, East Germany, Ireland, and Hong Kong. Arms, Suzanne, Immaculate Deception, Houghton-Mifflin, May, 1975.

(10) Fruma Ginsburgh MD, interviewed April 15, 1980.

change." (11) "Mothers began to resent being treated as though birth was invariably a high-risk event. Parents began to resent the fact that the doctor would get the credit for their 40 weeks' work with a one-hour appearance at the very end." (12)

Out of this anger grew many consumer childbirth groups. These groups were (and are) very important. They publish information about birth and choices in childbirth. They often have newsletters. The hold childbirth education classes, and can provide pregnant women and their families with a support network.

Childbirth consumer groups were the first to offer childbirth education classes. Hospitals later followed suit. Mary Terrell points out that these groups provided an educational base and a movement in which to act. (13) They have been very influential in advocating change in hospitals.

The best-known of these groups is the International

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(11) Mary Terrell, interviewed April 28, 1980.

(12) Alice Roemer, interviewed April 23, 1980.

(13) Mary Terrell, interviewed April 28, 1980.

Childbirth Education Association (ICEA), founded in 1960. Based in Wisconsin, it has chapters across North America. It runs childbirth classes, trains instructors, and publishes audiovisual materials on birth. Many of the most prominent actors in the change in childbirth movement have worked with the ICEA.

La Leche League International has over 2,600 groups in the United States and other countries. Established in 1957, this group offers support to women who are breastfeeding. The give classes and form networks of nursing mothers.

The National Association of Patents and Professionals for Safe alternatives in Childbirth (NAPSAC) publishes a quarterly newsletter. It also runs a research center for family-centered nonroutine obstetrics. Its membership includes not only parents, but medical professionals and childbirth educators.

The Association for Childbirth at Home International (ACHI) was founded in Boston in 1970. It is probably the largest single organization dedicated to homebirth. It offers classes in preparation for homebirth, and publishes a newsletter. It also runs a mail-order bookstore.

There are many other childbirth groups, both local and national. (14) These groups have provided the backbone and much of the work and effort that has brought about the changes in childbirth we see today.

## 4.4 Social movements

The change in birth took place during a time of many changes. It was one of many societal changes fed by the whole ethos of the late 1960s and early 1970s. The change in birth was part of several of these social movements, and should be understood in that context.

The women's movement: The first, and probably the most visible of these is the women's movement, which started in the mid-sixties, and was seriously under way by the early 1970s. A clear indication of how far it had gotten was the passage by Congress of the Equal Rights Amendment, an amendment which had been submitted each of the preceding fifty years. The National Organization for Women grew rapidly, reaching from the cities into the suburbs to middle-class, well-off women and men. When

(14) See The Birth Primer by Rebecca Rowe Parfitt, pp187-200, Signet, New York, 1980.

these people began to fight for changes in hospital childbirth, they had the economic and social clout to back up their fight.

The women's health care movement was a natural outgrowth of the women's movement. This was a major, easily identified area in which individual control and choice were seen to be lacking, with serious consequences for individual women. Many women began to feel that as patients, they were being treated poorly by male physicians, who did not believe them to take them seriously when they talked about their health. The risks of the IUD, birth control pills, and unnecessary drugs and surgery became important issues. The warnings of unnecessary medical intervention carried over to childbirth. Women began to reject anaesthetia and insist on natural childbirth. Some women rejected the hospital entirely, and turned to homebirth.

One clearly identified problem was the lack of information about women's health care available to women. Understanding one's own body was seen as a way of gaining control over the medical care process, and as one way of gaining control of one's life.

The Boston Women's Health Book Collective, originally a discussion group studying women's health care, published the

book Our Bodies, Ourselves on newsprint in 1971. Later, they published two more editions with Simon and Schuster. More and more books and publications containing women's medical information began to be popularly disseminated. Many of these were about childbirth. Women could now obtain information independently of their physicians.

Self-help health groups formed. As women learned to monitor their own health, they found that they did not need to rely as much on physicians. This, and the increased availablility of information, gave women the confidence and knowledge to push for change in obstetrics.

Much of the women's movement ideology concerned control over one's own life and the freedom to make choices. These choices covered a wide range of issues basic to how women live their lives: changing the division of labor within marriage, working outside the home, remaining unmarried, becoming lesbians. The basic issue, however, was control: women should make their own choices, and not let them be made by their parents, husbands, bosses or children.

A massive dissemination of information about the ideology of the women's movement was crucial to the spread of the

movement. Many books were written and read, and the women's movement received much exposure in newspapers and magazines, and on radio and television.

The women's movement and its committment to choice and women's control over their own lives was pervasive. This can probably be credited for helping many women find the power and legitimacy to demand the care and services they wanted from physicians, particularly in the area of childbirth.

Patient rights and informed consent: Another movement starting around the same time as the women's movement was the beginning of the patients' rights movement. This was marked by an increase in the number ofmalpractice suits against physicians, particularly involving lack of informed consent on the part of the patients.

In the early 1960s, there was an important increase in cases in which informed consent was at issue. (15) However, there was little legislative or case law on which to decide these cases. By the mid-1960s, courts across the nation had

(15) This followed two widely publicized cases, Nathanson v. Kline, 186 Kan. 393, P.2d 1093 (1960), and Mitchell v. Robinson, 334 S.W.2d 11, 79 A.L.R.2d 1017 (Mo., 1960).

adopted a "community practice standard". The amount and type of information a physician was required to provide was determined by what was usual and customary among physicians in the area. One commentator at the time proclaimed, "If it's good medical practice, it's good law." (16)

By the early 1970s, however, the community standard had been giving way in the courts in some states, including California, Pennsylvania, New Mexico, and Wisconsin, to a full disclosure rule:

> A physician's duty to disclose is not governed by the standard practice in a community; rather, it is a duty imposed by law. . . The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill Such evaluation and decision is a nonmedical judgement reserved to the patient alone. (17)

The court decisions had the effect of making physicians more aware that their actions were open to nonmedical scrutiny and that they were no longer the only judge of the patient's good. This also acted as a force to make physicians more responsive to consumer demands in birth practices.

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(16) Donald Hagman, The Medical Patient's Right to Know the "Truth", 1964, UCLA, Los Angeles, California.

(17) Cobbs v. Grant, 8 Cal. 3d 229, 502 P.2d 1 (1972)

Recently, patients' bills of rights have begun to appear in many hospitals and clinics. The American Hospital Association has established a standard bill of rights for its members' use. Patients' bills of rights have even been codified into law. In 1979, the Massachusetts legislature passed a patients' rights bill covering patients in hospitals, clinics, nursing homes, and other facilities licensed by the Departments of Public and Mental Health. (18) Patient advocates are beginning to appear at many hospitals.

Distrust of professionals: On a societal level, a distrust of many types of professionals was growing. The public as a whole was becoming better-educated and better able to make their own judgements. The information in the late 1960s and early 1970s about pollution, radiation, drug side effects, and other second-order technological effects gave lay people good reasons to distrust professionals and begin making their own judgements.

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(18) Patients' and Residents' Rights -- Medical and Mental Health Facilities, Massachusetts General Laws, Chapter 214, Section 70E. See Appendix G.

In obstetrics, the poor showing of the United States infant mortality rates, as compared with other industrialized countries (19) was in itself reason enough to doubt that the doctors were all-knowing. As information about drugs given during pregnancy, such as Diethylstilbestrol, (20) and drugs given during labor, particularly anaesthetics (which can have adverse effects on the infant) became known, medical credibility was damaged still further.

## 4.5 Summary

Obstetrics is innately different from many medical procedures because there is time to plan, many women go through the experience more than once, one can ask one's friends about it, and it is not normally a medical trauma. Due to declining birth rates, hospital and physicians have had to compete for obstetrical patients. Competition, demand, and consumer

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(19) See footnote 9 on page 47.

(20) Diethylstilbestrol, known as DES, was given to women with a history of miscarriage. Their daughters are now beginning to show a much higher rate of a rare form of vaginal cancer than women whose mothers were not exposed to DES. DES daughters, as they have come to be known, also have more difficulty conceiving. See "DES Daughters: New Studies, Same Results", Science News 117(12):182, March 22, 1980.

preference have become issues, making the market for obstetrical care similar to a standard market.

Information about birth and choices in birth are now available to women through books and independent groups. The obstetric patient is not dependent on her physician for obstetrical information. Childbirth consumer groups can be credited with much of the work in the process of childbirth change.

Changes in childbirth can be seen in the context of the women's movement, the patients' rights movement, and the disaffection with professionals characteristic of the late 1960s and early 1970s.

# Chapter 5: Conclusions

We have seen how radically obstetric care has changed in response to competitive pressure. This chapter will outline what can be learned from the obstetrical case, and where else in medicine it can be applied.

## 5.1 Characteristics innate to obstetrics

There are four characteristics innate to obstetrics, which make the market for obstetrics more like a standard market and less like the market for most forms of medical care.

- Time: Time allows the patient-consumer to shop around, compare doctors, and listen to friends' stories about particular doctors and hospitals. Time also allows for learning about alternatives in childbirth. Clearly, not all medical situations allow one the luxury of time to plan, but many do. Time allows the patient-consumer to gather information and then make decisions on the basis of this information. Thus, time allows for at least the possibility of choice.

- Trauma and the perceived importance of physician skill: In obstetrics, most people are handed a healthy baby at the end, regardless of how the birth is handled. In situations that lack trauma and where the outcome is fairly certain, consumers can feel more confident in insisting on having physicians and hospitals cater to them. In situations that are perhaps more dependent on the physician's skill (e.g. open-heart surgery), patients are unlikely to look for the physician most sympathetic to their views. They will look for the most skilled physician.

  In situations where there is a high risk of death or impariment, even if the skill of the physician makes little difference in the outcome, patients will probably still choose skill over service. The perceived value of skill will be higher than service if the perceived stake is greater

- Repetition: If patients go through a procedure more than once, they can learn from their own experience, which can be applied to subsequent repetitions of the procedure. Repetition gives patients a basis for comparison, and therefore a way to form judgements independent of

physicians.

- Commonality: If a procedure is common, propsective patients can obtain information about the procedure from people who have undegone it previously. This again provides a way of making judgements independent of the physician.

There is a continuum of procedures wherein routine preventive care (check-ups, well-baby care, etc.) shares the preceeding features of obstetrics, namely time, repetition, lack of trauma, commonality. This should be unsurprising since birth is a normal function of the body. At the other end of the continuum is emergency acute care (e.g. heart attacks, emergency appendectomies). Between these extremes are planned procedures, elective surgery, long-term chronic care, and acute non-emergency care.

How close a procedure is to the obstetrical model probably determines how much innate leeway there is in the procedure for consumer pressure. Routine care, for example, shows the results of such pressure. Physicians are more concerned now with explaining what they are doing and listing a patient's options.

## 5.2 Non-innate factors affecting obstetrics today

There are three other factors in today's market for obstetrical care that make it more susceptible to consumer pressure. These factors are not innate to the process of birth, but are societal and temporal. As such, under the right conditions, they could apply to any medical procedure.

- Competition: Competition between medical care providers, whether hospitals, physicians, or other practitioners, causes health care providers to be responsive to consumer preferences and desires. This provides important leverage for the consumer. A provider will accomodate patients in ways the patients feel are important, if the provider has reason to believe that many of her patients will go elsewhere if she does not.

- Consumer information: When consumers need not rely solely on physicians for information, they can make independent choices about medical care. This kind of learning takes many forms: childbirth education classes, childbirth organizations' literature, and popularly available books on childbirth. This availability immediately reduces the

physicians' informational role to that of being one of several sources. One of the valuable things about the information avaliable on birth is its diversity. Some of it is written by medical professionals, some by patients' rights activists. Some authors question the established roles of the physician and the hospital, while others don't. Many viewpoints are represented.

What is lacking for many other medical problems and procedures is readily available information about them, written for and understandable by consumers. What literature exists is often not very complete, or written by physicians for patient management. However, the amount of information available to the consumer is growing, notably in the area of cancer care.

- Consumer movements and groups: Consumer movements provide public exposure of issues. Consumer groups supply independent information, act as lobbying groups, and provide a support network for individual patients, and for those working for change.

## 5.3 Essential factors for consumer choice

The most important feature of birth is the amount of time available before the birth to plan, gather information, and shop around. Without time, choices cannot be considered or made. Even if the market is competitive, without time to make choices, competition will not provide for consumer choice.

Another critical factor for consumer choice is competition. If it is a seller's market, there is usually little room for choice. Even in this case, however, very motivated consumers and consumer groups can affect the market.

The next essential factor for consumer choice is the absence of a perceived need for the physician's skill. In order to exercise choice in medicine, the consumer must be willing to question her physician. She must be willing to admit to herself after a time that she has been undergoing the wrong course of treatment, and switch providers.

The more traumatic the illness and the higher the stakes, the more likely it will be that the patient will have a strong need to trust her physician and to believe that her physician

is doing everything possible to help her. Without the willingness to question, make demands of, or switch providers, having time to plan or a market that is competitive will not cause consumer choice in consumers too scared to choose.

The last essential factor is information on which to base choices. (1) Without available information, having the time and willingness to plan do not enable consumers to make independent choices. A competitive market, with many providers, implies at least the ability to shop around and get some information that way.

Other sources of information include learning through both one's own and others' experiences (repetition and commonality), and information from consumer groups. (2) Popularly available books and publications are often the result of a consumer movement. Advertising, another form of information, is usually the result of competition. Media coverage can be the result of either.

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(1) For a proposal on how understandable medical information might be more widely distributed, see appendix D.

(2) Ideally, all high school students would receive this information as part of their educations. See appendix E for a proposal on how this might be done.

Consumer movements and consumer groups cannot change the amount of time for planning that exists in a particular medical situation. They can, however, affect the three other essential factors for consumer choice. By heightening consumer awareness of the issues involved in a particular medical procedure, they can cause patients to be more selective and encourage them to put pressure on their physicians, thus increasing competition in the market.

Consumer movements can affect how individuals view their circumstances. They can affect the perception of how much physician skill matters, and can occasionally cause awareness that physicians should not be trusted blindly.

Consumer groups in obstetrics have their most visible impact on information distribution. They, and individual writers working with them, have produced a wide range of readily-available information. Medical providers react by distributing their own publications. This competition in medical information results in more information to the consumer, even provider-generated, than would exist without competitive pressure in information.

Consumer information lowers the consumer's need to trust

her physician, and sharpens her ability to make her own medical choices. Thus, the medical consumer starts to behave more like a consumer in a non-medical market. This type of behavior on the part of many consumers leads to a more competitive market.

## 5.4 Other medical markets

Pediatrics: Besides obstetrics, another medical market that has begun to respond to competitive forces is the hospital pediatrics market. It is also showing the effects of the declining birth rate, with a decrease in patient population. Small pediatric wards are being closed in many places.

Pediatric wards in many hospitals are being refurbished with playrooms and kitchens. Parents may now stay overnight with their children. These changes are very similar to birthing rooms and having fathers present at deliveries in obstetrics.

Cancer: Cancer therapy is a good example of a market that is responding to consumer movement pressure. Unlike obstetrics and pediatrics, with their decline in occupancy rates, as we introduce more and more carcinogens into our environment, the

number of cancer patients increases. A patient's discovery that she has cancer is very traumatic. The desire to trust the physician is very strong, particularly since the treatment often feels worse than the disease, at first.

Cancer consumer groups once only concentrated on providing a support network for cancer victims. They are now pushing for more treatment alternatives, full disclosure of these by the physician, and are disseminating information on their own.

Results of consumer pressure can be seen in the new patients' rights law in Massachusetts, which provides for "the right to informed consent to the extent provided by law." Interestingly enough, only one disease is singled out for individual mention: "In the case of a patient suffering from any form of breast cancer, [the patient shall have the right] to complete information on all alternative treatments which are medically viable. (3) Appropriately, the breast cancer issue is in the intersection between women's health care issues and cancer care issues. (4)

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(3) Patients' and Residents' Rights -- Medical and Mental Health Facilities, Massachusetts General Laws, Chapter 214, Section 70E."

(4) For a proposed standard for physician disclosure for medical care in general, see Appendix F.

Cancer chemotherapy patients used marijuana illicitly for many years, and still do. Marijuana treatment for the side effects of chemotherapy is now beginning to be studied seriously because of pressure from consumer groups. Laetrile treatment, which most physicians think is quackery, has been legalized in several states, because consumers have pushed for it. Studies of its efficacy are being performed, not because physicians think it shows promise (as with marijuana), but because there is so much popular interest in it.

Geriatrics: The market for geriatric medicine has the features of time and lack of trauma, but the other side of the declining birth rate, the increasing proportion of elderly people in the population, has caused an increased need for beds. The lack of competitive pressure shows in that consumers have not had much in the way of an effect on the market. With "grey liberation" we can probably expect to see a comsumer movement in geriatrics, which may, despite the current lack of competitive pressure, come to affect the market in a similar manner to cancer care.

## 5.5 Regulation

As we have seen in obstetrics, competition between hospitals, between physicians, and between physicians and other providers provides considerable leverage for consumer demand. It seems unwise, therefore, to close small obstetrical and other units, as this will, over time, remove competition as a means of improving care to patients.

The standard argument for closing small obstetrical units is that they are less safe and cost-effective than large units. Results of safety studies are mixed, but they show that at least in some areas small obstetrical units are as safe as large ones. (5) (6) (7) Some smaller hospitals are combining obstetric and certain kinds of gynecological care, thus making

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(5) Nagaraja, Urabagilu, "Should Small Rural Community Maternity Departments Be Closed?", Connecticut Medicine, Vol. 39, No. 8, pp507-8.

(6) Klein, Michael C. and Apostolos N. Papageorgiou, "Can Prenatal Regionalization be Reconciled with Family-Centered Maternal Care?", Journal of Family Practice, Vol. 5, No. 6, 1977, p969.

(7) Fleck, Andrew C., "Hospital sizes and outcomes of pregnancy", Office of the Assistant Commissioner for Child Health, New York State Department of Public Health, Feb. 23, 1977.

previously underutilitzed wards cost-effecient. The danger in closing small units and consolidating services is that an oligopolic situation is created.

An oligopoly is a situation, similar to monopoly, in which a few corporations dominate a marketplace. Oligopoly involves less competition, and higher prices. These firms usually have very similar prices because it becomes more profitable to support the other oligopolists' high prices than to undercut and obtain a larger share of the market. These firms also share a common goal of preventing potential competitors from entering the market.

Unlike most commodities, medical care cannot be transported across the country. Only a small portion of the population can and will travel long distances to obtain medical services. This means that an oligopolistic situation can be created in a local area without forming the huge corporations that would be necessary to be part of an oligopoly in most industries.

An oligopolic situation will almost certainly have negative effects for consumers. Their ability to affect hospital policy by "voting with their feet" will be hampered if

the number of hospitals competing for patients is substantually reduced. The possibility that prices might go up with reduced competition should not be overlooked.

It should be recognized that there is a tradeoff between competition and cutting beds. While cutting beds may appear to lower hospital costs, overbedding creates a situation very responsive to consumer demand. Perhaps there ought to be a performance standard which emphasizes safety, cost-effectiveness, and length of stay, rather than a minimum size specification.

Regulatory bodies tend to regulate all forms of care in the same way. One lesson that can be drawn from the obstetrical case is that all medical markets are not the same, particularly with regard to the amount of time available to the consumer for planning and the amount of trauma associated with the need for that medical service. Consideration should be given to deregulating those markets where competition and standard market forces are operating. Scarce regulatory resources could then be concentrated in areas where they are more needed, for example, those services involved with treatment for emergencies and traumatic illnesses.

## 5.6 Role for families and friends in the hospital

There is also another lesson we can learn from the obstetrical example. Patients want control and support in the hospital. The do not want to feel helpless and isolated.

Pediatrics is similar to obstetrics in that a person that is not the patient has credibility in making decisions for the patient. In the pediatric case, the parents must make decisions for the child. In the obstetrical case, the father is viewed as having a legitimate interest because the child being born is his. In both these cases, a person whose faculties are intact, i.e. not impaired by illness or pain, is interacting with the physician and hospital staff. This person can be far more of an advocate for the patient than the patient could be for herself.

For most women, the major improvement in hospital childbirth has been the presence of fathers and other support people. A greater role for family and friends as patient support people in the hospital would probably make the experience of being hospitaized much less frightening and isolating for most patients. It would also give them an

advocate when they are too weak to fight for themselves.

Many of the changes in hospital obstetric policy about fathers and parents could be extended to other hospital services. Visting hour restrictions could be removed too allow 24-hour visiting, and facilities could be provided for a support person to stay overnight with the patient. (8)

Now that it has been shown that fathers can be present at cesarian sections (which are major surgery) without disruption or increase in infection, why not allow patients to have support people with them in operating rooms for other procedures? Like cesarian sections, many surgical procedures that are currently performed under general anesthesia could be done under local anesthesia. (9)

Even with procedures done under general anesthesia, however, the patient may feel more at ease knowing that someone

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(8) This is already being done in many hospitals for pediatric patients. A parent stays with the child and sleeps on a rollaway cot.

(9) Local anesthesia has several advantages over general. The fear of going under or being unconscious is removed. Since the patients is awake, the procedure is not as mysterious. The risks of general anesthesia are removed. Also, procedures performed under local anesthesia provide more of a role for the support person.

they know is there, if only to catch "you're operating on the wrong leg" types of mistakes. (10) Also, the support person, by reporting what happened while the patient was out can demystify the procedure, and allay fears.

The physician does not fill this role through her discussion with the patient. First, the physician does not usually have time to describe and discuss in detail what happened. Secondly, the patient may feel silly or uncomfortable asking certain questions of the physician (e.g. "Did I say anything while I was under?"). Thirdly, in talking to patients, it is often difficult for a physician or other provider to remember and compensate for the information she takes for granted. If a physician is in an operating room every day, it is difficult for her to think of all the things that someone who has never been in one would want to know.

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(10) Clearly, this sort of thing happens very rarely, but horror stories and attendant patient fears abound.

## 5.7 Summary

Many of the factors present in the market for obstetrical care are generally missing from medical markets. These factors make the market for obstetrical care more like a standard market than like that for medical care.

Four of these characteristics are innate to obstetrical care: Planning time, repetition, commonality, and lack of trauma. Three factors are societal or temporal: competition, consumer groups, and availability of information. Planning time, competition, lack of perceived trauma (and its associated need to trust the physician), and availability of information are essential for a medical market to be responsive to consumer choice. Repetition, commonality, and consumer groups can all be considered sources of information.

Consumer groups and movements cannot affect the amount of planning time available, but they can affect the perceived need to trust the physician and hence competition and consumer ability to affect change. The cancer care market is an example of this. Pediatrics, with a declining occupancy rate, shows similarities to obstetrics. Geriatric medicine, like cancer

care, has increasing numbers of patients, but with an associated social movement, may show behavior similar to that of cancer care.

Regulators should be careful not to remove competition when trying to lower costs. Markets for medical care are different from one another, and should be regulated differently. Scarce regulatory resources should be concentrated on those medical markets that cannot and do not have competitive forces working in them, particularly the markets for emergency care and treatment of traumatic illness.

Finally, non-obstetric patients could also benefit from having a support person with them in the hospital to make the experience less isolating and to give them an advocate. This could include removing visiting hour restrictions and allowing support people into operating rooms.

## Appendix A: Survey letter, questionnaire and data

Fifty hospitals across the United States were surveyed to document the changes in birth practices. Out of fifty, twenty-two responded. They ranged in size from 281 to 6138 births in 1979, and from 8 to 70 obstetrical beds.

Only one of the hospitals which responded to the survey allowed fathers to be present at deliveries in 1955. Fathers are now allowed to be present at all normal vaginal deliveries, and, in most hospitals, at those with complications. (1) While none of the hospitals resonding allowed fathers to be present at cesarean sections in 1955, over half now allow fathers to be present at cesarean sections performed under local anesthesia. One hospital also allows fathers to be present for cesarean sections done under general anesthesia. In approximately half the hospitals, fathers are actually present only 35-50% of the time. In the other half, fathers are present 75-95% of the time.

None of the hospitals offered childbirth classes in 1955. All but one of the hospitals responding now offer childbirth classes. (2) Only two hospitals reported extended visiting hours for fathers in 1955. None allowed sibling visits, that is, visits by a woman's other minor children, in 1955. In 1980, all hospitals report extended visiting hours for fathers. Over eighty percent of the hospitals now allow sibling visits.

In all the hospitals surveyed, the proportion of patients receiving general anesthesia has gone down. There is, however, a wide regional variation. For 1955, three hospitals report a general anesthesia rate of from 90-98%, three other hospitals report that none was used. All the hospitals estimate that women in labor are receiving a lower level of barbiturates now than in 1965.

Just over one third of the hospitals responding have or

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(1) One hospital does not allow fathers to be present at vaginal deliveries with complications. Another allows them to be present at forceps deliveries, but not if the woman is hemorrhaging.

(2) The hospital that does not offer classes reports that they are available in the community.

are opening birthing rooms. One is in the process of establishing an out-of-hospital birthing center to open this year. Most of the birthing rooms have opened recently, i.e. three-fourths have opened or will open this year.

Only two of the hospitals surveyed have nurse-midwives practicing in them, although three-fourths are in areas that allow nurse-midwives to practice. Another hospital permitted nurse-midwives to practice in 1955, although it no longer does so.

Nearly three-fourths of the hospitals reported an increase in breastfeeding since 1955. One hospital reports a decrease, and the rest (over 20%) say that there has been no change.

With one exception, all the hospitals surveyed have rooming-in. In 30% of the hospitals, rooming-in is for all babies; in the remaining hospitals rooming-in is available by request. None of these hospitals had rooming-in in 1955.

The proportion of patients undergoing cesarean sections has risen at all the hospitals. Cesarean section rates for 1955 vary between 1-2% and 10%, while current cesarean section rates range between 9.6% and 33%.

## Survey Results

1. Year hospital established

This ranged from 1873 to 1970; the smaller hospitals (fewer than 1000 deliveries per year) ranged mostly from 1950 to 1970.

2. Number of obstetrical beds:

This table ranks, in reverse order of size (in 1980), the of deliveries in 1955 and 1980, the number of beds, and the number of deliveries per bed in 1980, and whether there were more or fewer deliveries in 1980 than in 1955. It is followed by a list of averages over all hospitals.

| Deliveries in 1980 | Deliveries in 1955 | Number Beds | Deliveries per bed | More/Less in 1980 |
|---|---|---|---|---|
| 6138 | 2157 | 64 | 96 | More |
| 4889 | 3850 | 70 | 70 | More |
| 4824 | 3140 | 46 | 105 | More |
| 3900 | 700 | 40 | 97 | More |
| 3877 | ? | ? | | |
| 2800 | 2700 | 40 | 70 | More |
| 2200 | 4553 | 38 | 58 | Less |
| 1843 | ? | 32 | | |
| 1500 | ? | 32 | | |
| 1421 | more | 38 | | Less |
| 1417 | 784 | ? | | More |
| 1378 | ? | 24 | | |
| 1208 | 1244 | 30 | 40 | Less |
| 773 | 1259 | 22 | 35 | Less |
| 654 | 200 | 15 | 44 | More |
| 612 | 540 | 19 | 32 | More |
| 611 | 200 | 14 | 44 | More |
| 600 | ? | 11 | | |
| 528 | ? | 12 | | |
| 540 | 990 | 14 | 39 | Less |
| 427 | 89 | 8 | 53 | More |
| 281 | ? | 20 | | |
| Avg: 1928 | 1600 | 30 | 58 | 10 More<br>5 Less |

Table 1.

3. Is your hospital (check all that apply)

13 of 22 hospitals checked more than one answer.

| | | |
|---|---|---|
| teaching | 10 | |
| private | 5 | |
| public | 9 | |
| nonprofit | 16 | |
| proprietary | 0 | |
| religious affiliated | 1 | (Catholic) |
| other | 2 | (Health Care Memb., Teaching affiliate) |

4. Number of live births (if exact number is not known, please estimate):

See Table 1 for figures from both 1955 and 1980.

5. Does your hospital offer childbirth classes for expectant parents?

In 1980: 21 of 22 offered courses.
In 1955: None offered courses.

6. Does your hospital have extended (beyond regular) visiting hours for fathers?

In 1980: All 22 have extended visiting.
In 1955: Only 2 had extended visiting.

7. Are fathers allowed to be present at normal vaginal deliveries?

In 1980: All 22 allow fathers to be present.
In 1955: Only 1 allowed fathers to be present.

Please estimate the proportion of fathers present during normal vaginal deliveries:

In 1980: Percentages range from 35 to 95 percent, averaging 60 percent.
In 1955: All were zero, save for one at 50 percent.

8. Are fathers allowed to be present for vaginal deliveries with complications (e.g. forceps deliveries)?

   In 1980: 21 of 22 allow fathers to be present.
   In 1955: 1 of 22 allowed fathers to be present.

9. Are fathers permitted to be present for cesarean sections performed under local anesthesia?

   In 1980: 12 of 22 allow fathers to be present.
   In 1955: None allowed fathers to be present.

10. Are fathers permitted to be present for cesarean sections performed under general anesthesia?

    In 1980: 1 of 21 allow fathers to be present.
    In 1955: None allowed fathers to be present.
    One hospital does not perform cesarean sections under general anesthesia.

11. Does your hospital have rooming-in facilities (i.e. can the baby stay with the mother, rather than in the nursery)? If the hospital has rooming-in, is it for all babies or only by request?

    In 1980: 21 of 22 have rooming-in facilities.
    In 1955: None had rooming-in facilities.

    16 of 22 will provide rooming-in by request.
    5 of 22 will always provide it. These were all large (more than 1000 deliveries/year) hospitals.

12. Does your hospital have facilities which permit fathers to stay overnight?

    In 1980: 3 of 22 have overnight facilities.
    In 1955: 2 of 22 had overnight facilities.

13. Are obstetrical patients permitted visits by their other minor children?

    In 1980: 18 of 22 allow visits by minors.
    In 1955: 0 of 21 allowed visits by minors.

14. In your hospital, would you estimate that there are more, fewer, or about the same number of mothers breastfeeding in 1980 than in 1955?

16 of 22 reported more,
5 of 22 reported about the same, and
1 of 22 reported fewer.

15. Are nurse-midwives permitted to practice in your state and community?

17 of 21 report yes,
4 of 21 report no.

16. Do nurse-midwives practice in your hospital?

In 1980: 2 of 22 employ midwives to practice.
In 1955: 1 of 19 employed midwives to practice.

17. Does your hospital have birthing rooms (single "home-like" rooms used for normal labor and deliveries)? When were they first introduced?

7 of 22 presently operate birthing rooms.
2 of 22 have them under construction, or have applied for construction permits.

All were introduced in 1979 and 1980, except for one in 1976.

18. Does your hospital have an out-of-hospital birthing center affiliated with it? When was it established?

1 of 22 has such a center, which is scheduled to open later in 1980.

19. Please estimate the proportion of patients receiving general anesthesia for vaginal delivery?

Answers varied widely. All 14 hospitals reporting data for 1955 reported a smaller percentage for 1980 than for 1955.

1955: Range from 0 to 90 percent. Average 60 percent.
3 of 14 report 90 percent or more.
4 of 14 report 2 percent or less.
1980: Range from 0 to 35 percent. Average 4.7 percent.
2 of 22 report 33-35 percent.
4 of 22 report between 5 and 10 percent.
16 of 22 report less than 2 percent.

20. Please estimate the proportion of patients undergoing cesarean sections.

All 12 hospitals reporting data for 1955 reported a larger percentage for 1980 than for 1955.

1955: Range from 1 to 10 percent. Average 5.7 percent.
1980: Range from 10 to 33 percent. Average 15.7 percent.

21. In your hospital, would you estimate that women in labor are receiving a level of barbiturates that is lower or higher in 1980 than in 1965?

21 of 21 report a lower usage level of barbiturates.

Appendix A Survey letter, questionnaire and data

The survey letter:

April 15, 1980

Sample Hospital
Main Street
Anytown, USA 00000

Dear Obstetrical Unit Director,

I am a graduate student in Health Planning at the Massachusetts Institute of Technology. I am working on an analysis of changes in the management of childbirth during the last 25 years. This study seeks to document changes in hospital delivery of obstetrical services in different sizes and types of hospitals.

Your hospital has been selected to be one of the thirty hospitals from across the country surveyed. Your response is important to the success of this study. I have tried to structure this survey so it will take only a few minutes of your time.

I greatly appreciate your help and cooperation in completing this questionnaire. If you would like to receive the results of this study, please so indicate in the answer to the last question.

Thank you for your time and effort.

Sincerely,

Naomi Pless

## Hospital Childbirth Practices Questionnaire

The time period that this survey concerns is from 1955 through 1980. If your hospital was opened after 1955, please use the first year of operation wherever the survey says 1955. In cases where the information reqeusted is difficult or impossible to obtain, please give a reasonable estimate (and indicate that you have done so) or just leave the space blank. Thank you for your time and assistance.

1. Year hospital established _____

2. Number of obstetrical beds _____

3. Is your hospital (check all that apply)

   ____ teaching

   ____ private

   ____ public

   ____ nonprofit

   ____ proprietary

   ____ religious affiliated (which? _____)

   ____ other (please explain) _____

4. Number of live births (if exact number is not known, please estimate):

   _____ 1979 _____ 1955

5. Does your hospital offer childbirth classes for expectant parents?

____ yes ____ no

Were they offered in 1955?

____ yes ____ no

6. Does your hospital have extended (beyond regular) visiting hours for fathers?

____ yes ____ no

Did your hospital have extended visiting hours for fathers in 1955?

____ yes ____ no

7. Are fathers allowed to be present at normal vaginal deliveries?

____ yes ____ no

Were they allowed to be present in 1955?

____ yes ____ no

Please estimate the proportion of fathers present during normal vaginal deliveries:

_____ now

_____ 1955

8. Are fathers allowed to be present for vaginal deliveries with complications (e.g. forceps deliveries)?

____ yes ____ no

Were they allowed to be present in 1955?

____ yes ____ no

9. Are fathers permitted to be present for cesarean sections performed under local anesthesia?

____ yes ____ no

Were they allowed to be present in 1955?

____ yes ____ no

10. Are fathers permitted to be present for cesarean sections performed under general anesthesia?

____ yes ____ no

Were they allowed to be present in 1955?

____ yes ____ no

11. Does your hospital have rooming-in facilities (i.e. can the baby stay with the mother, rather than in the nursery?)

____ yes ____ no

Did your hospital have rooming-in in 1955?

____ yes ____ no

If the hospital has rooming-in, is it for

____ all babies ____ by request

12. Does your hospital have facilities which permit fathers to stay overnight?

____ yes ____ no

Did your hospital allow fathers to stay overnight in 1955?

____ yes ____ no

13. Are obstetrical patients permitted visits by their other minor children?

____ yes ____ no

Were such visits permitted in 1955?

____ yes ____ no

14. In your hospital, would you estimate that there are
____ more mothers breastfeeding in 1980 than in 1955?
____ fewer mothers breastfeeding in 1980 than in 1955?
____ about the same?

15. Are nurse-midwives permitted to practice in your state and community?

____ yes ____ no

16. Do nurse-midwives practice in your hospital?

_____ yes _____ no

Were they permitted to practice in 1955?

_____ yes _____ no

17. Does your hospital have birthing rooms (single "home-like" rooms used for normal labor and deliveries)?

_____ yes _____ no

When were they first introduced? _____

18. Does your hospital have an out-of-hospital birthing center affiliated with it?

_____ yes _____ no

When was it established? _____

19. Please estimate the proportion of patients receiving general anesthesia for vaginal delivery?

_____ in 1955

_____ now

20. Please estimate the proportion of patients undergoing cesarean sections

_____ in 1955

_____ now

21. In your hospital, would you estimate that women in labor are receiving a level of barbiturates that is

____ lower in 1980 than in 1965?

____ higher in 1980 than in 1965?

22. Do you wish to receive the results of this study?

____ yes

____ no

If yes, to whose attention should the results be directed?

_____

It would be appreciated if this survey could be returned by April 30, 1980. If you have further questions or comments, do not hesitate to enclose them with this survey.

Thank you for your time and effort.

# Appendix B: Interviews

## Interview: Constance Bean

Connie Bean is the patient advocate for the MIT Medical Department. She has had extensive involvement with the consumer movement to change birth practices. She is a member of the International Childbirth Education Association, and has written several books on childbirth. (1)

Changes: While she believes that there have been changes for the better in hospital obstetrics, she feels that there are also changes for the worse. Among those for the better, she mentions the availability of birthing rooms and rooming-in, more LeBoyer births and the options of delayed cord cutting or delayed silver nitrate drops, more breastfeeding, and less moving of the mother from room to room. The fact that women are no longer given general anesthesia and are given fewer barbiturates, which means that women are now awake during

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(1) Labor and Delivery, Doubleday, 1977.
Methods of Childbirth, Doubleday, 1974.

childbirth, she sees as very positive.

Changes which have affected fathers as well as mothers include the presence of fathers during labor and delivery, women awake at cesarean sections and fathers present at them, fathers allowed extended visiting hours beyond regular visitors, and, in some parts of the country, that fathers can stay with the mothers and infants overnight. In addition, there are now gimmicks to make new parents more comfortable: champagne, dinners by candlelight, etc.

On the negative side, Ms. Bean mentions mothers being confined to bed in hospitals, and the often limited access of mothers to their babies. She believes that routine intravenous feedings (IVs), episiotomies, and fetal heart monitoring, especially of the type that requires breaking the amniotic sac, are unnecessary and harmful. She questions the rate of use of pitocin and the insistence that women give birth in the lithotomy position. She also points out that there is no one person who coordinates an individual's care in a hospital. Patients have to deal with many different people and are moved from room to room in the birthing process.

Ms. Bean is also troubled by the way that babies are

treated in the hospital. She mentions baby warmers which use dry radiant heat, bilirubin lights, routine vitamin K, and circumcisions performed with no anesthetics on two-day-old, strapped-down infants. Also, sugar water is given to infants in the nursery, which interferes with the mother's attempts to breastfeed.

Ms. Bean feels that professional education is lacking, that physicians are taught and believe misinformation. She is disturbed that many dangerous procedures are third-party reimbursible, and points out that there is no consumer input into what is reimbursible.

Reasons for changes: Ms. Bean mentions many reasons why childbirth has changed. She points to legal cases, such as a 1963 suit against Beth Israel Hospital in Boston, and the Brazelton Report (see section 2.3), which she credits with eliminating the use of seconal during labor and delivery.

Ms. Bean says that women started choosing hospitals that would let men in. With declining occupancy rates, smaller hospitals used this to compete with larger ones. Hospitals were also losing people to homebirth. Ms. Bean suggests that hospitals are unknowingly scaring people with their high

cesarean rates. In addition, she says that there are now better nurses in obstetrics. Nurses formerly did not like obstetrics, because they were not dealing with aware people, just strapped-down bodies.

Ms. Bean asserts that the importance of people having a lot of information on which to base their decisions. She sees her books as a means of passing on her knowledge to others. She credits the Boston Association for Childbirth Education (BACE) in the 1960's for their publicity and childbirth classes. Childbirth classes now, Ms. Bean claims, are watered down in terms of content, and are larger.

Ms. Bean points out that some professionals also helped change the way childbirth is handled. She mentions that some of the information about change is coming through hospital articles and advertisements about birthing rooms. One problem she mentions with distributing information is that it tends to be distributed differentially to the elite.

Ms. Bean gives credit to the LaLeche League in the late 1960s for having helped women feel confident about nursing. Other consumer groups she cited were Homebirth and the International Childbirth Education Association. She points out

that good births are a good experience for women, and men.

Interview: Fred Frigoletto MD

Fred Frigoletto MD is the Chief of Professional Services at the Boston Hospital for Women, and director of the obstetrical unit there.

Changes: Dr. Frigoletto feels that there are many positive changes in obstetrics since 25 years ago. He mentions the increased interest shown by an increasing number of patients in natural childbirth. These patients are less afraid of childbirth than patients were 25 years ago, he says. They want an active part in the process; formerly, they wanted, as much as possible, to be unaware of the process.

Other changes are technology-related. These changes have led to satisfaction and successful pregnancies for women who otherwise might not have had them. The most important of these changes are those in perinatal care, particularly neonatal intensive care. Also, improvements in prenatal genetic screening, such as amniocentesis, allow the possiblility of careful decisions about whether to continue pregnancies.

Finally, techniques are being developed to actaully provide a certain amount of care for the fetus while in utero.

Reasons for changes:

The primary reasons for the changes in the way women view and react to pregnancy are "a variety of psycho-social phenomena," according to Dr. Frigoletto. Better education about pregnancy is available to those women who are interested. Physicians have responded to consumer demands, he says: "That's what sells." Twenty years ago, he says, women wanted to be knocked out during delivery, and they were. Now that women want to be awake, physicians will be accommodating. Physicians, he says are basically humanists; they are willing to do whatever pleases their patients, as long as it is not harmful.

Dr. Frigoletto points out that technical changes have developed from laboratory research programs, and are not related to consumer demands. Consumers, clearly, could not know what technical changes were coming unless they were involved with the research.

Interview: Fruma Ginsburgh MD

Fruma Ginsburgh MD is an obstetrician-gynecologist at the MIT Medical Department. She has been practicing for 25 years, and received her training in Philadelphia.

Changes: Dr. Ginsburgh states that there have been many changes in childbirth in the last 25 years, and feels that they are very positive, beneficial changes. She mentions that parents are becoming more informed, and that fathers are participating and being helpful. She says that formerly women were assumed to know very little, and that there was no point in telling them anything, a view that she characterizes as reactionary and provincial. She says that such attitudes have changed.

Dr. Ginsburgh feels that hospitals now have more flexible rules. She mentions fathers present at cesarean sections, rooming-in for babies, and sibling visits. The trend toward breastfeeding has been helped by improved support on the part of pediatricians. Dr. Ginsburgh says that the trend in hospitals now is toward as little as possible in the way of medication, and that patients wanted more in the past. She

feel that childbirth classes help women want less medication. She also mentions a greater range in choices of medication, including very minimal medication, and epidural anesthesia. Dr. Ginsburgh points out that family planning has resulted in planned births, and older first-time births. She says that this has resulted in more committed parents, and wanted children.

Dr. Ginsburgh is happy that she trained in Philadelphia, because it was well ahead of Boston in humanizing births. They had some fathers at normal deliveries. Rooming-in was available. Breastfeeding was popular. General anesthesia was given by patient's choice. Scopalomine was rarely given. She stresses that there are regional differences in the handling of birth.

Dr. Ginsburgh also mentions many medical-technical changes which she feels have made childbirth much safer than 25 years ago. The maternal death rate has dropped tremendously since then. High-risk babies often turn out much better now. There are more living, undamaged infants. She gives part of the credit to neonatal intensive care units.

Dr. Ginsburgh says there is much greater emphasis now on

detecting problems in advance of birth. She mentions many medical innovations which have greatly increased the ability to detect problems before birth, such as ultrasound scanning, blood tests, amniocentesis, etc. She also mentions the improved chances for diabetic women giving birth, the rubella vaccination, availability of blood for transfusions, and the development of Rhogam to prevent the Rh sensitization. Dr. Ginsburgh also feels that the liberalized use of cesarean section, instead of difficult forceps deliveries has also increased the number of healthy babies.

Dr. Ginsburgh feels that the fetal heart monitor is another beneficial development, despite the anxiety of some women about being hooked up to a machine. Although she is uncomfortable with the idea, she says there is a question as to whether routine monitoring is cost-effective.

The only negative change Dr. Ginsburgh sees is the trend towards birth at home. She quotes an American College of Obstetricians and Gynecologists' study of death certificates which showed a two-to-five times greater risk of stillbirths among low-risk mothers delivering at home than among low- and high-risk mothers delivering in a hospital. She says it is painful for her to see women choosing homebirth.

Reasons for changes: "Women were angry and demanded change," says Dr. Ginsburgh. She mentions that younger obstetricians gained an understanding and appreciation of the problems in obstetrics as their wives went through the birth process in hospitals. As younger obstetricians changed their practices, older ones had to adjust to keep their patients.

She feels that change was possible because childbirth is much safer now. The maternal death rate has dropped tremendously in the last 25 to 30 years, she points out. Dr. Ginsburgh mentions that some older physicians "felt for their patients," and were flexible. She says that where obstetrical chiefs were dead set against change, nothing would happen, but that many were flexible.

Interview: Judy Luce

Judy Luce has been a lay midwife for about three years. She has an agreement with an obstetrician who serves as a back-up provider, and has admitting privileges at a local hospital.

Changes: Ms. Luce feels that the most positive changes in childbirth are related to changes in attitude on the part of mothers and families. She points to a change in consciousness in women about their bodies. Women have more confidence in their bodies' ability to give birth unaided. She says it is a fear of birth that leads women to give birth in hospitals. She sees the increase in the number of women giving birth at home as a very positive change.

Ms. Luce sees parents taking more responsibility for birth as a healthy phenomenon. She feels that "babies belong with mothers," and is pleased that women and families are more conscious of their integrity now.

Ms. Luce does not feel that hospitals are good places to give birth, particularly for women who do not need highly technical care. She does feel, however, that there have been some improvements in hospital management of birth, particularly the presence of fathers and siblings at birth, rooming-in, and a de-emphasis on hitherto routine preparatory procedures.

Ms. Luce feels that many of the changes in hospital birth procedures are negative. She points out that the cost of

hospital birth has increased more than that of any other hospital procedure. In general, birth in hospitals has become more technology and intervention oriented. Fetal heart monitoring, because it requires breaking of the amniotic sac, increases the rate of infections and thereby causes an increased rate of cesarean sections. Routinely-used epidural anesthesia causes maternal blood pressure to drop, which leads to slowed labor. Pitocin is then required to speed up the labor. Between the blood pressure drop and the often very sharp contractions which accompany pitocin, the baby goes into fetal distress, and an emergency cesarean is required. Ms. Luce also points to an increased rate of malpresentation with epidural anesthesia, because the woman is immobile. She terms the greatly increased rate of cesarean sections "frightening", and is especially worried about routine second cesarean sections.

Ms. Luce mentions that in hospitals, almost all vaginal births are performed in lithotomy position, where the woman lies flat on her back with her knees up. This, she says, is done for the convenience of the attending staff; in fact, birth is more difficult in this position than in others. Rather than having gravity to help push the baby out, as in a sitting or squatting position, the woman's contractions have to push the

baby against gravity.

Ms. Luce is also upset that so many babies are still put in nurseries, away from their mothers. She stresses the importance of body contact between babies and their parents. Ms. Luce indicates that classes held in hospitals are more geared to physicians' needs for parents to be prepared for the hospital birth experience, and less to offering parents information about choices they can make. Hospitals do not offer the "natural childbirth" classes that lay groups used to run -- they are now "prepared childbirth" classes.

Reasons for changes: Ms. Luce believes the changes in hospital birth are in response to the homebirth movement. She says that physicians and hospitals wanted to save people from homebirth. Consumer pressure was also a factor in hospital change; women wanted change, but many were afraid to give birth at home.

Ms. Luce traces this fear to a number of sources. She suggests that professionals do not encourage women to think of their bodies as capable because it makes the work of the professional easier. Women are told that they are not responsible for birth. The responsibility is the physician's. She points to an implicit societal promise that technology well

make everything better, including babies. She says that the labor, pain, or work involved in giving birth are seen as unpleasant in our society.

Ms. Luce believes that many women are fearful because their mothers' fears have been passed on to them. The high rate of cesarean sections worries many people. Ms. Luce mentioned being told "everyone in my office has had a cesarean." Everyone has heard a story about someone or her baby who was saved by the doctor. Ms. Luce suggests that many of these rescues are necessitated by side effects of intervention. Ironically, she says, fear may inhibit a woman's ability to labor and give birth. She may, therefore, require more intervention. Ms. Luce suggests that a woman's lack of confidence in her ability to give birth carries over to a lack of confidence to mother. She believes that "what happens at birth has life-long effects on a woman's role as a mother."

Ms. Luce sees the trend toward homebirth as a reaction to what happens in the hospital. Women afraid of the frequent interventions in hospitals. (2) She states that you lose freedom and control in a hospital. She warns that anesthetics

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(2) As a minor example, Ms. Luce mentions that episiotomy rates are aroud 90% in the hospital and 10% at home.

used in labor and delivery are dangerous for infants. She says that anything introduced into the body has to have side effects. Many people give birth at home because they feel that it is safer than in a hospital. "Birth should be a process," she says, "of moving from a womb to a womb with a view."

Consumer information: Ms. Luce is disturbed not only by the cesarean section rate, but is also disturbed at how the risks of cesarean section are explained to women. She explains that while women are told what the risks are for their babies, the risks of cesarean section to the mother (five times the death rate of vaginal delivery) are never explained. She is troubled that no value is placed on a woman's bodily integrity. She says that people's rights are violated in hospitals all the time, and that the right to choose is never permitted.

Interview: Alice Roemer

Alice Roemer is the Clinic Director for Maternal and Child Health at the Mount Auburn Hospital in Cambridge, Massachusetts. She holds a Master's Degree in Public Health, and is a Registered Nurse. She has been at the Mount Auburn hospital for three years.

Changes: Ms. Roemer feels that changes in hospital obstetrical practices have been concentrated in two main areas: greater control of the birth process by parents, and a diminished degree of blind faith on the part of consumers in the members of the medical community. As more consumer-oriented information has become available (3) and consumers have become more knowledgeable in the field of obstetrics, they have begun to insist on their right to know about and control their birth process.

Perhaps the most striking example of greater control by consumers has been the reduction in the use of anesthetic agents during labor and delivery. Ms. Roemer says that birth is no longer a mysterious process that women go through in a medicated stupor. New mothers would emerge hours or days later to find their infants in their arms (or in the nursery, until the scheduled feeding time). Women, she says, are also receiving less analgesic drugs. Ms. Roemer also mentioned a year-old regulation from the Food and Drug Administration which prohibits the use of pitocin for induction of labor without a specific medical indication of its necessity.

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(3) She mentions Marjorie Karmel's Thank You Doctor Lamaze as the first consumer-oriented birth book.

Ms. Roemer also outlined other ways in which consumers are taking control of the birth situation. Women may choose to have a nurse-midwife birth as their primary birth attendants. Fathers or other support persons are now present at nearly all births occurring at Mount Auburn. Fewer patients are undergoing the ritual of prep and enema which obstetricians formerly imposed upon them. There are now home-like birthing rooms in which a woman can both labor and give birth in a setting which is less mechanized and medical. Siblings of the infant are able to visit the mother and child in the hospital, and may be permitted to attend the birth. (4)

Another change at Mount Auburn, she said, was the new nursery policy. The hospital has established special-care nurseries which allow 24-hour visits by parents, thus effectively abolishing feeding schedules, and have a special nurse assigned to each infant to assure continuity of care. She also mentioned that a hospital in Rome, NY allows older siblings to hold and play with infants. Their preliminary findings showed no increase in infection among the infants, implying that there was no harm in permitting children to meet

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(4) Children who attend births must be accompanied by an adult who is not the mother's support person.

their infant siblings.

One alarming trend that Ms. Roemer notes is that medical students are receiving less training in the management of difficult births, such as breech presentations, except through cesarean section. This has two consequences, namely that more cesarean sections are performed, and that women may actually be safer having a cesarean section rather than a difficult vaginal birth which the physician is ill-prepared to do. Most medical students, she says, never learn how to massage a perinuem, or how to deliver a breech presentation vaginally, nor anything about how to make labor easier.

Reasons for changes: Ms. Roemer feels that the primary motivation for changes in hospital management of birth is a response to loging patients to the homebirth movement. In the 1960's, various consumer groups, communes, lay midwives and others began to question medical care in general, and began conducting births at home. They discovered that births at home work -- most women can give birth safely, with no lacerations or other harmful effects. These, along with other developments in women's health care brought about by the women's movement, taught women that their bodies "could do it", that is, that most women could give birth relatively easily without the help

or interference of medical personnel.

Other parents, although still using normal medical services for birth, began asking questions of their doctors, such as "is this the right way to give birth?" Mothers began to resent being treated as though birth was invariably a high-risk event. And parents began to resent the fact that the doctor would get the credit for their 40 weeks' work with a one-hour appearance at the very end.

Hospitals and doctors began to respond to consumer pressure in the face of the competition from home births and nurse-midwives. Ms. Roemer suggests that there are three motivations for their response. First, there is the issue of lost revenue. Each birth at home is one less for which a consumer pays a doctor and a hospital. Secondly, some doctors are genuinely concerned about the 5-10% of women who cannot give birth normally. These high-risk women, they feel, cannot always be screened out in advance, and thus all pregnant women would be safer if hospitalized. Finally, there are many doctors who are are philosophically troubled by the notion of birth at home. In Ms. Roemer's words, it reminds them of appendectomies on the kitchen table.

Childbirth education classes, at first conducted by lay groups such as Homebirth and ICEA, and later by hospitals, have both given parents a great deal of information, and encouraged them to ask questions of the obstetrician before and during labor and delivery. As parents learn from their classes that they have choices about various aspects of the birth experience, they have gone to their physicians and demanded to be allowed to make these decisions.

Consumer information: "Most parents don't know their rights," Ms. Roemer asserts. For example, if a physician is not treating a patient in a way which the patient likes, the patient may ask the physician to get her another physician. Failure to do so is called abandonment, and is a criminal offense. Furthermore, a patient is entitled to select all physicians treating her, including the anesthesiologist.

It is important to select an obstetrician carefully. She suggests that prospective parents shouldn't be afraid of spending money to shop around and interview several doctors. ACOG publishes a list of guidelines for obstetric practice which she says would serve as a good checklist for patients to have. Furthermore, she suggests that parents should seriously consider hiring a midwife. "Midwives will put themselves out

for you, but not doctors," Ms. Roemer states. "They spend more time with each patient, taking time to let nature take its course".

She feels that several kinds of changes need to combine to improve obstetrical services. Women need to be more aware of their rights and options. She feels people should be educated in high school about pregnancy and birth. Consumers need to continue to put pressure on the medical community.

Over the past 25 years, women have gotten the idea that their bodies can't function well enough to have babies normally, Ms. Roemer says. This makes the woman very vulnerable when she goes in for medical help. (5)

Women are also concerned about whether they fit the stereotype of attractiveness that society expects of them. They try to minimize their weight gain during their pregnancy, (6) thus endangering both themselves and their unborn child.

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(5) Ms. Roemer says that the childbirth instructors who work with her can usually pick out the women who will need cesareans, becuase they don't have confidence in themselves.

(6) So they can fit into their designer jeans six weeks after their child is born, Ms. Roemer says wryly.

(7) Also, many women are convinced that they need an episiotomy, so that they will be able to please their partners sexually after their pregnancy.

Advice to pregnant patients: "It's not easy for some people in the medical community to accept changes [in the treatment of pregnancy]; they tend to view all pregnancies as life-threatening," Ms. Roemer warns. In some parts of the country, husbands are still not permitted to attend their wives' childbirths. In many places, it is heresy to talk about fathers at a cesarean section.

Ms. Roemer says that often when a woman comes in before labor has actually started, the medical staff will get "itchy" after about twenty-four hours, and, with a diagnosis like "failure to progress in labor", will perform a cesarean. "If you come in early, you're asking for it," she says.

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(7) Ms. Roemer mentioned one woman who died because she put herself on the Scarsdale Diet during her pregnancy.

Interview: Mary Terrell

Mary Terrell is currently working for Abt Associates, a consulting firm in Cambridge, Massachusetts. Prior to working at Abt, she was a health planner in the Helath Planning Office of the Massachusetts Department of Public Health planning office. She holds a Master of Public Health degree and is a Registered Nurse.

Changes: Ms. Terrell sees many changes in the hospital birth experience since her first child's birth. At that time, she says, she "had to fight for everything". She was discouraged from breastfeeding her child, her husband could not participate in the birth, she had to insist on getting information from doctors and nurses. It was difficult to for her get the natural childbirth she wanted.

Now, however, she says it is standard practice for the husband or significant other to be present at the birth. Mothers are encouraged to nurse their infants. Nurse-midwives are allowed to attend hospital births. Usually a nurse-midwife provides the mother with a great deal of information during the

course of the birth. A mother and her child usually stay together for the duration of their hospital stay. Also, many births are more "natural" than they were 25 years ago: mothers are less drugged and participate in the process more than they did.

Some of the changes Ms. Terrell sees are negative. The higher cesarean section rate is one example. Cesarean section carries a higher risk to the mother. Also, since it is difficult to determine the gestational age of the fetus, more infants born by cesarean section are premature.

The increased rate of prematurity increases the need for neonatal intensive care units. These, along with fetal heart monitors, other technological innovations, and cesarean sections are increasing the cost of childbirth. This is not surprising, Ms. Terrell feels, in view of the declining birth rate; in order to maintain their earning power, obstetricians must earn more per patient by performing more expensive procedures.

Ms. Terrell also cites the increased degree of control that the obstetrician exerts over the birth process. In many instances, for example, the woman's placental membrane is

broken so that a fetal heart monitor may be attached to the scalp of the fetus. More and more, physicians are bringing large-scale technological intervention into the birth process. She mentioned a study she for which she had done the research but was not able to complete, which showed a pattern of elective induction.

Reasons for changes: Many of the positive changes, Ms. Terrell says, are due to women saying they want them. Consumer groups such as Homebirth and Birthright are providing consumers with an educational base and a movement in which to act.

Doctors, she feels, are responding to this consumer movement, and not to pressure from within the medical community. Ms. Terrell feels that "nurses and doctors did not do their jobs" in reforming the birth process. Rather than initiating change, they responded to economic pressures brought about, in part, by the declining birth rate and reduced number of obstetric patients. She says that the changes were not planner-initiated.

Furthermore, the changes which are bringing nurse-midwives into the hospital are a direct response to economic pressures. Women have indicated that they prefer to be attended by

nurse-midwives rather than doctors for normal births. Ms. Terrell quoted one obstetrician who, referring to the nurse-midwife he recently brought into his practice, said "she's worth her weight in gold."

The negative changes are brought about, in part, by the educational process that all obstetricians go through. She notes that many physicians are trained to do cesarean sections in part because they're exciting to do, and reinforce the physician's feeling of control over the process.

Future changes in obstetrics: Ms. Terrell sees nurse-midwives having a difficult time improving their status within the medical profession. "You can't make headway by threatening the livelihood of obstetricians," she states. Thus, the position of nurse-midwives within their profession is not likely to improve without a big push from the women's movement. She feels that nurse-midwives will make headway mostly pporer or rural in areas that are underserved by physicians, and be unable to break into urban markets such as Boston. She feels that another form of competition between nurse-midwives and physicians will emerge as a result of the declining birthrate: there will be fewer births on which to train obstetricians, and nurse-midwives will also be competing for training.

Other changes she sees include an increase in the use of birthing rooms in hospitals. She thinks that there will probably not be a large increase in the number of out-of-hospital birthing centers, however.

Desirable changes in obstetrics: Ms. Terrell feels that fetal heart monitors and neonatal intensive care units represent largely misspent money. She feels that the money would be better spent on preventive medical care for pregnant women, rather than on the end stages of neglect. (8) There is no interest in prevention among the medical community, Ms. Terrell says. "The American Medical Association, which is a powerful lobby, believes in medical care, not prevention."

The role of planners in changing obstetrics: Ms. Terrell feels that while individual planners may have their own separate ideas, that there is no planner-initiated movement toward improving obstetrics in Massachusetts. Partly, this is due to the fact that planners only control the medical profession in economic and regulatory ways. She says that while she was

(8) "Within sight of the Boston Hospital for Women, we have several neighborhoods where prevention would be useful. These neighborhoods have an infant mortality rate of over 20 per thousand live births."

working for the Department of Public Health, she tried to have the state encourage change, rather than block it. Thus, the State Health plan for 1979 established goals which are in favor of increasing the number of nurse-midwives, out-of-hospital birth centers, and alternative birth approaches. Also, she tried to add patient-consumers to the state health plan task force which is responsible for making changes to the state obstetric regulations.

# Appendix C: Nurse-midwives in Massachusetts

CERTIFIED NURSE-MIDWIVES BY AFFILIATION

MASSACHUSETTS, 1978

| Institutions | Number of Certified Nurse-Midwives Full Time | Part-Time |
|---|---|---|
| Boston Hospital for Women | 2[a] | 2[a] |
| Brookside Family Life Center Jamaica Plain | 3[b] | |
| New England Ob/Gyn Associates | 1[b] | |
| Beth Israel Hospital | 3[a] | |
| South Cove Community Health Clinic | 1[b] | |
| Boston City Hospital | 2[b] | |
| Whittier Street Health Clinic | 1[b] | |
| Cambridge Nurse-Midwife Associates | 1[a] | |
| Haverhill Ob/Gyn Associates | 1[b] | |
| TOTAL | 15 | 2 |

Notes:

a: Full Practice (includes delivery)

b: Prenatal and Post Partum Care

Source: Helena McDonough, R.N., C.N.M., M.S. Chairperson, Massachusetts Section of the American College of Nurse-Midwives.

## Appendix D: Information dissemination

One lesson we can learn from the obstetrical case is that there can be many ways of treating a medical condition. For this reason, patient informational literature must be diverse. If it is written solely by physicians for patients, then the situation has not improved greatly from the model of the individual physician as sole informational source. Concurrently, information must be disseminated from non-medical sources. Literature disseminated from the physician's office can be, only reasonably, expected to contain information concurring with the physician's view of illness and treatment. Information must be available in local libraries and bookstores, and from advocacy groups.

One problem that often arises with dissemination of information is that the information reaches highly-educated people much more easily and rapidly than those with less education. Information about alternative sources of medical information should exist at the source of medical care. Patient advocacy groups should make special efforts to reach out to less-educated, less-well-off segments of society.

Local public libraries should be part of a nationwide medical information network, with information either there of available from a state or district library. Information would be divided into easily-accessible categories by disease or injury. Physicians' offices, hospitals, clinics, nursing homes, and other medical providers would be required tc indicate through notices (written in appropriate languages) that the library information was available.

Notice of the availability of information should exist at many community gathering places besides hospitals and physicians' offices. These could include grocery stores, mental health centers, churches and synagogues, pharmacies, YWCAs and YMCAs, schools, and workplaces. Some businesses make a point of providing community information or community bulletin boards (for example, some copy shops, bookstores, health food stores). Community centers (be they recreational, teen, women's, men's, gay) are also clearly apporpriate places. Public service advertising on radio, television, and in newspapers and magazines, which is often free, would be another place to advertise information availablility.

## Appendix E: Proposal for a health education program

In the childbirth case, it is clear that informed and educated consumers are better able to make their own choices and exert consumer pressure. People learning, in high school, to take responsibility for their health and health care would be learning a valuable life skill. Similarly, adult education geared to the same goals would also be valuable. I see health and health care education as requiring a four-part curriculum:

Information about the body and how it functions: This would consist of a clear overview of body organs and major systems, as well as what each does to maintain or aid function in the body. The second part of this section would cover what to do (preventively) to maintain health, including diet, exercise, and cautions on drug use. The third part of this section, would cover occupational safety and health. Safety in working with chemicals, mechanical equipment, and fibrous materials (especially asbestos) would be covered. How and where to obtain up-to-date information on these substances in the future, or on substances not covered would be discussed.

Procedures: What's going on?: This would cover what basic

medical diagnostic procedures test for, how they work, and why they are done. To whatever extent it is comfortable and possible, this should folow the self-help model, with students learning to take blood pressure, test reflexes, etc. Students would be taught how to interpret laboratory test results. Common non-routine diagnostic procedures would also be discussed. Treatments (and options) for common major illnesses (cancer, diabetes, etc.) would be covered. Students would be taughts to evaluate the risks and benefits of drug and surgical procedures.

Medical information: How do I find out about it?: This would cover how to get more information about a particular disease, injury, drug, procedure, occupational chemical or substance. Library skills would be taught, with emphasis on basic medical references, how to use them and how to read them. Techniques for referencing medical journals would be taught. Federal, state and local community resources for information would be identified (particularly for occupational health). Students would be taught how to go about learning more about whatever kind of medical problem they or their friends or family members were having.

How to deal with physicians/providers: They're selling, you're

buying: Students would be taught how to interview physician/ providers and get the information they want from them. The first step in this would be to discuss student's feelings about physicians. Do they feel intimidated, anxious, scared, angry when they are with physicians? Students would be taught assertiveness and relaxation skills to help them deal more effectively with physicians. Discussion and role-play of the authority role expected by patients of physicians should help break down inbred role models and expectations. Students should be encouraged to respect physicians who give them information readily and share uncertainties, rather than those who "play god".

Students would be taught what their rights are under the law:

- Malpractice: the right to sue for damages resulting from poor medical practice or negligence.
- Informed consent: the right to sue for damages resulting from good medical practice, but where informed consent was not given. This is considered negligence under the malpractice laws.
- Patients' rights laws: these give many rights, but exist in only a few states.
- Right to refuse treatment or withdraw consent at any time: treatment given without consent (1) or against the

(1) This does not apply to a situation where consent is

patient's will is assault, and the physician is liable for a criminal offense.

- Right to choose one's physician: This seems obvious, but it also includes the right to choose one's anesthesiologist and other "unseen" physicians.
- Abandonment: If one decides that one no longer wants one's physician, under the law that physician is obligated to find a replacement. Failure to do so is abandonment.

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unobtainable. For example, in an emergency situation where the patient is unconscious and family members cannot be reached

## Appendix F: Physician Accountability

If the goal is to increase consumer choice, the patient-consumer must understand the choices in order to choose. This is the central problem in the informed consent issue. Since it is not possible to allocate choice directly, the focus is on allocating information in the hopes that information will permit choice. Physicians could be required to be more responsible for assuring their patients' knowledge, through stricter informed-consent laws, or through better monitoring or enforcement of these.

The inequities in the current information distribution process are clear -- physicians have access to much more medical information than patients. Some lay people may know how to get medical information, although many will not wish to spend the time and effort to find and decipher information written for medical people. People who are assertive and able to be insistent with their doctors may also have an advantage over those who are not. By changing present laws or regulations to require full disclosure of information, medical information could be made much more accessible.

Full distribution of information could be defined to be when every patient has all the information necessary to make as knowledgeable as possible a choice between all available alternatives. Full information should include:

1. A listing of all the alternative treatments available. Non-treatment should always be considered to be an alternative.

2. All the risks, both large and small, of the treatment, its alternatives, and of non-treatment, clearly explained.

3. A clear and complete description of the procedures involved in the treatment and its alternatives.

4. The itemized costs of each alternative, and how much is or is not covered by any insurance the patient has.

5. Information about the physician's (or other provider's) qualifications and ability to perform the contemplated procedures.
   i. Where did s/he learn to perform the procedure? Was it part of her/his training?

ii. How many times has s/he done it before, and how recently?

iii. How does her/his success rate with this and similar procedures compare with the general rate of success?

6. The following information about the physician should always be available:

i. What medical school s/he attended

ii. Where s/he did her/his internship or residency program.

iii. Whether s/he is board eligible or certified, and in what specialties.

7. Where relevant, what hospital will the procedure be done in? What choices does the patient have in this regard?

i. choice of hospital

ii. choice of floor or particular service

iii. type of room

iv. type of visiting privileges

Further rights of hospital patients are covered very well and in detail in the Massachusetts Patients' Rights Bill, Massachusetts General Laws, Chapter 214, Section 70E. See Appendix G.

Presently, the only way informed consent laws are enforced is through malpractice suits in the courts. This has several disadvantages. The number of suits filed is affected by a number of things, including knowledge on the part of the patient that s/he can sue, the availablity of an attorney, and the doctor's skill (under present law, a suit cannot be brought unless harm has been done).

To improve the situation, possible alternative measures might include:

1. Monitoring of the availability of informational literature in hospitals, clinics, doctor's offices, and public libraries, as well as the completeness of available literature. Easily available, clearly written medical information on a wide variety of topics is crucial to the informed consent process. It is too easy for physicians to miss things, either deliberately or accidentally, and all too likely, given the time pressure under which most physicians work. (See appendix D.)

2. Hospital Review Boards could be made responsible for overseeing and ensuring that patients get enough information to give informed consent. Provision should be

made for consumer representation on these review boards.

3. A number of patients could be surveyed every year as to whether they feel they have received enough information to give informed consent. The surveying could be done by the hospitals, by Departments of Public Health or other licensure agencies, or by consumer groups.

4. Hospitals could be required, through licensure regulations or legislation, to have a patient advocate on the staff, who would be required to monitor physician and hospital compliance with informed consent regulations.

# Appendix G: Patients' bill of rights

## PATIENTS' AND RESIDENTS' RIGHTS—MEDICAL AND MENTAL HEALTH FACILITIES

### CHAPTER 214.

**An Act providing certain rights to patients and residents in hospitals, clinics and certain other facilities.**

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

**Chapter 111** of the General Laws is hereby amended by inserting **after section 70D** the following section:

**Section 70E.**

As used in this section, "Facility" shall mean any hospital, institution for the care of unwed mothers, clinic, infirmary maintained in a town, convalescent or nursing home, rest home, or charitable home for the aged, licensed or subject to licensing by the department; any state hospital operated by the department; any "Facility" as defined in section three of chapter one hundred and eleven B; any private, county or municipal facility, department or ward which is licensed or subject to licensing by the department of mental health pursuant to section twenty-nine of chapter nineteen; any "Facility" as defined in section thirty-eight of chapter one hundred and twenty-three; the Soldiers' Home in Holyoke, and the Soldiers' Home in Massachusetts.

The rights established under this section shall apply to every patient or resident in said facility. Every patient or resident shall receive written notice of the rights established herein upon admittance into such facility, except that if the patient is a member of a health maintenance organization and the facility is owned by or controlled by such organization, such notice shall be provided at the time of enrollment in such organization, and also upon admittance to said facility. In addition, such rights shall be conspicuously posted in said facility.

Every such patient or resident of said facility shall have, in addition to any other rights provided by law, the right to freedom of choice in his selection of a facility, or a physician or health service mode, except in the case of emergency medical treatment or as otherwise provided for by contract, or except in the case of a patient or resident of a facility named in section fourteen A of chapter nineteen; provided, however, that the physician, facility, or health service mode is able to accommodate the patient exercising such right of choice.

Every such patient or resident of said facility in which billing for service is applicable to such patient or resident, upon reasonable request, shall receive from a person designated by the facility an itemized bill reflecting laboratory charges, pharmaceutical charges, and third party credits and shall be allowed to examine an explanation of said bill regardless of the source of payment. This information shall also be made available to the patient's attending physician.

Every patient or resident of a facility shall have the right:

(*a*) upon request, to obtain from the facility in charge of his care the name and specialty, if any, of the physician or other person responsible for his care or the coordination of his care;

(*b*) to confidentiality of all records and communications to the extent provided by law;

(*c*) to have all reasonable requests responded to promptly and adequately within the capacity of the facility;

(*d*) upon request, to obtain an explanation as to the relationship, if any, of the facility to any other health care facility or educational institution insofar as said relationship relates to his care or treatment;

(*e*) to obtain from a person designated by the facility a copy of any rules or regulations of the facility which apply to his conduct as a patient or resident;

(*f*) upon request, to receive from a person designated by the facility any information which the facility has available relative to financial assistance and free health

care;

(g) upon request, to inspect his medical records and to receive a copy thereof in accordance with section seventy, and the fee for said copy shall be determined by the rate of copying expenses;

(h) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological, or other medical care and attention;

(i) to refuse to serve as a research subject and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;

(j) to privacy during medical treatment or other rendering of care within the capacity of the facility;

(k) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of the source of payment unless such delay can be imposed without material risk to his health, and this right shall also extend to those persons not already patients or residents of a facility if said facility has a certified emergency care unit;

(l) to informed consent to the extent provided by law; and

(m) upon request to receive a copy of the bill or other statement of charges submitted to any third party by the facility for the care of the patient or resident.

Every patient or resident of a facility shall be provided by the physician in the facility the right:

(a) to informed consent to the extent provided by law;

(b) to privacy during medical treatment or other rendering of care within the capacity of the facility;

(c) to refuse to be examined, observed, or treated by students or any other facility staff without jeopardizing access to psychiatric, psychological or other medical care and attention;

(d) to refuse to serve as a research subject, and to refuse any care or examination when the primary purpose is educational or informational rather than therapeutic;

(e) to prompt life saving treatment in an emergency without discrimination on account of economic status or source of payment and without delaying treatment for purposes of prior discussion of source of payment unless such delay can be imposed without material risk to his health;

(f) upon request, to obtain an explanation as to the relationship, if any, of the physician to any other health care facility or educational institutions insofar as said relationship relates to his care or treatment, and such explanation shall include said physician's ownership or financial interest, if any, in the facility or other health care facilities insofar as said ownership relates to the care or treatment of said patient or resident;

(g) upon request to receive an itemized bill including third party reimbursements paid toward said bill, regardless of the sources of payment; and

(h) in the case of a patient suffering from any form of breast cancer, to complete information on all alternative treatments which are medically viable.

Any person whose rights under this section are violated may bring, in addition to any other action allowed by law or regulation, a civil action under sections sixty B to sixty E, inclusive, of chapter two hundred and thirty-one.

No provision of this section relating to confidentiality of records shall be construed to prevent any third party reimburser from inspecting and copying, in the ordinary course of determining eligibility for or entitlement to benefits, any and all records relating to diagnosis, treatment, or other services provided to any person, including a minor or incompetent, for which coverage, benefit or reimbursement is claimed, so long as the policy or certificate under which the claim is made provides that such access to such records is permitted. No provision of this section relating to confidentiality of records shall be construed to prevent access to any such records in connection with any peer review or utilization review procedures applied and implemented in good faith.

No provision herein shall apply to any institution operated or listed and certified by The First Church of Christ, Scientist, in Boston, or patients whose religious beliefs limit the forms and qualities of treatment to which they may submit.

No provision herein shall be construed as limiting any other right or remedies previously existing at law.

Approved May 23, 1979.

# BIBLIOGRAPHY


----, Cases on Consent to Treatment, Law Division of the American Medical Association, 1966.

----, Legislative fact sheet 1975-76, in re Massachusetts House Bill 1568, distributed to the Governor's Commission on the Status of Women, March 15, 1976.

----, Patients' and Residents' Rights -- Medical and Mental Health Facilities, Massachusetts General Laws, Chapter 214, Section 70E.

----, "Childbirth Center Responds to Demands for More Family Participation: New York City.", Hospitals 50:11-12, September 1, 1976.

----, "DES Daughters: New Studies, Same Results", Science News 117(12):182, March 22, 1980.

----, "Hospitals Bow to Couples Wanting Special Births: Chicago", Medical World News 18:38-9, October 3, 1977.

----, "New Childbirth Care Concept Emphasizes Family Contact", Hospitals 52(17):22, September 1, 1978.

----, "Patients' Complaints: Survey Data", Medical Economics 55:197, October 16, 1978.

----, "Should Fathers Attend Cesarian Section Deliveries?", AORN Journal 28(3):434-5, 438-9, passim (editorial), September 1978.

Annas, George J., The Rights of Hospital Patients, Dutton, 1976.

Arms, Suzanne, Immaculate Deception, Houghton-Mifflin, May, 1975.

Arrow, Kenneth, "The Welfare Economics of Medical Care", The American Economic Review 53(5):941-73, 1963.

Atlee, H.B., "Is Gynecology Good for Obstetrics?", Canadian Medical Association Journal 117(10):1128, November 19, 1975.

# Bibliography


Auferio, Joan, "Midwives, Mothers Celebrate Birth", Sojourner, September, 1977.

Barnett, Mary, "Who Can Deliver a Baby?", Nation, 225 (1), July 2, 1977.

Bean, Constance, Labor and Delivery, Doubleday, 1977.

Bean, Constance, Methods of Childbirth, Doubleday, 1974.

Bean, Constance, Patient Advocate, MIT Medical Department, Interview, March 10, 1980.

Beischer, Norman A. and Eric V. MacKay, Obstetric and the Newborn, W.B. Saunders, Philadelphia, 1976.

Boston Women's Health Book Collective, Our Bodies, Ourselves, Simon and Schuster, New York, 1976.

Callon, Helen F., "Regionalizing Perinatal Care in Wisconsin", Nursing Clinics of North America, June, 1975.

Charles, A. G et al, "Obstetric and Psychological Effects of Psychoprophylactic Preparation for Childbirth", American Journal of Obstetrics and Gynecology 131(1):44-52, May 1, 1978.

Committee on Perinatal Health, Toward Improving the Outcome of Pregnancy, National Foundation-March of Dimes, 1976.

Corea, Gena, The Hidden Malpractice, Harcourt, Brace, Jovanovich, New York, 1977.

de Beauvoir, Simone, The Second Sex, Alfread A. Knopf, New York, 1952.

Detsky, Allan Steven, An Economic Analysis of Policy Issues in the Supply of Medical Services, PhD Thesis, Massachusetts Institute of Technology, 1972.

DeVries, Raymond G, "Responding to Consumer Demand: A Study of Alternative Birth Centers.", Hospital Progress, October, 1979.

Dreifus, Claudia, Seizing our Bodies -- the Politics of Women's Health, Vintage, 1977.

## Bibliography


Eastman, Nicholson J., Williams Obstetrics, Appleton-Century-Crofts, Inc., New York, 1950.

Ehrenreich, Barbara and Deirdre English, Witches, Midwives and Nurses: A History of Women Healers, Feminist Press, Old Westbury, NY, 1973.

Ehrenreich, Barbara and John, The American Health Empire: Power, Profits and Politics, Health Policiy Advisory Committee (Health-PAC), Random House, New York, 1970.

Fina, C., "Old Maternity Wing was Never Like This!", American Medical News 19:Impact/9, May 24, 1976.

Fleck, Andrew C., "Hospital Sizes and Outcomes of Pregnancy", Office of the Assistant Commissioner for Child Health, New York State Department of Public Health, Feb. 23, 1977.

Fried, Charles, Medical Experimentation, Personal Integrity, and Social Policy, American Elsevier, New York, 1974.

Friedan, Betty, The Feminine Mystique, W.W. Norton, New York, 1963.

Frigoletto, Fred, Chief of Processional Services, Boston Hospital for Women, Telephone interview, April 30, 1980.

Fuchs, Victor R., Who Shall Live ? Health, Economics and Social Choice, Basic Books, New York, 1974.

Gainer, Margaret F and Patricia M. Van Bonn, "Two Factors Affecting the Cesarian Delivered Mother: Father's Presence at the Delivery and Postpartum Teaching", University of Michigan School of Nursing, Ann Arbor, Mich, 1977.

Ginsburgh, Fruma, Obstetrician-gynecologist, MIT Medical Department, Interview, April 15, 1980.

Greer, Germaine, The Female Eunuch, McGraw-Hill, New York, 1971.

Hagman, Donald, The Medical Patient's Right to Know the 'Truth', 2d draft, 1964.

Heins, H.C. Jr, "Identification of the High Risk Obstetrical Patient: the Use of an Object Scoring Method", Journal of the South Carolina Medical Association 72:213-6, June

1976.

Hibbard, L.T., "Changing Trends in Cesarian Section", American Journal of Obstetrics and Gynecology 125:798-804, April 1976.

Hotchner, Tracy, Pregnancy and Childbirth, Avon, New York, NY, 1979.

Illich, Ivan, Medical Nemesis: The Expropriation of Health, Calder and Boyars, 1975.

Karmel, Marjorie, Thank You, Doctor Lamaze, Doubleday, 1974.

Klein, Michael C. and Apostolos N. Papageorgiou, "Can Prenatal Regionalization be Reconciled with Family-Centered Maternal Care?", Journal of Family Practice, 5(6):969, 1977.

Klaus, Marshall H, et al., "Maternal Attachment: Importance of the First Post-Partum Days", New England Journal of Medicine 286(9):460-3, March 2, 1972.

Luce, Judy, Lay midwife, Interview, April 18, 1980.

MacIntyre, S., "Management of Childbirth: a Review of Sociological research issues", Social Science and Medicine 11:477-84, May, 1977.

Maisels, M.J. et al, "Elective Delivery of the Term Fetus: an Obstetrical Hazard", Journal of the American Medical Association 238(19):2036-9, November 7, 1977.

Marsh, Frank, "An Ethical Approach to Paternalism in the Physician-Patient Relationship", Ethics in Science Medicine 4:135-8, March, 1977.

McLennan, Charles E., Synopsis of Obstetrics, Mosby, St. Louis, 1966.

Nagaraja, U., "Should Small Rural Community Maternity Departments be Closed?", Connecticut Medicine 39:507-10, August, 1975.

Nagaraja, Urabagilu, "Should Small Rural Community Maternity Departments Be Closed?", Connecticut Medicine, 39(8):507-8, ????.

# Bibliography

New York University Law Review, "Informed Consent -- a Proposed Standard for Medical Disclosure", 48 (548), June, 1973.

Nicholson, Marjorie E., "Maternity Care as Perceived by Newly-Delivered Mothers under the Care of Nurse-Midwives and Those under the Care of Obstetricians", Columbia University Teachers College, 1976.

Orwoll, Gregg, "Informed Consent: A Reincarnation?", Hospital Medical Staff, August, 1975.

Parfitt, Rebecca Rowe, The Birth Primer, Running Press, Philadelphia, 1977.

Rich, Adreinne, Of Woman Born, W.W. Norton, New York, 1976.

Rindfuss, R.R. and J.L Ladinsky, "Pattern of Births: Implications for the Incidence of Elective Induction", Medical Care 14:685-93, August, 1976.

Rising, Sharon, "A Consumer-oriented Nurse-midwifery Service", Nursing Clinics of North America, June, 1975.

Roeder, J.L, "Developing a System of Large Obstetrical Services", Hospital Health Service Administration 21:73-87, spring, 1976.

Roemer, Alice, Clinic Director for Maternal and Child Health, Mount Auburn Hospital, Cambridge, Massachusetts, Interview, April 23, 1980.

Sabolsky, Ann, excerpts from "The Power of the Forceps: A Comparative Analysis of the Midwife Historically and today", in WIN News 2 (4), p. 38, (Get date).

Salter, A, "Birth without Violence: a Medical Controversy", Nursing Research 27(2):84-8, March-April 1978.

Shamsi, Haider H, Roy H Petri and Charles M. Steer, "Changing Obstetric Practices and Amelioration of Perinatal Outcome in a University Hospital", American Journal of Obstetrics and Gynecology, April 15, 1979.

Sousa, Marion, Childbirth at Home, Prentice-Hall, Englewood, NJ, 1976.

# Bibliography

Terrell, Mary, Health Planner, Abt Associates, Cambridge, Massachusetts, former Planner for the Massachusetts Department of Pubic Health, Interview, April 28, 1980.

Trotter, R.J., "Changing the Face of Birth", Science News 108:106-8, August 16, 1975.

Wasserman, Michelle, "The New Nurse-midwives", Progressive, October, 1975, pp 32-35.

## Biographical Notes

Naomi Pless was born December 29, 1956 in Beth Israel Hospital in Boston. Her mother, as a result of her birth experience with Naomi, subsequently changed both obstetricians and hospitals, thereby anticipating this thesis by 23 years.

Naomi Pless attended the Cambridge School in Weston, Massachusetts before coming to MIT. She is a feminist and a humanist. The rest remains to be seen.