MATERNITY PATIENTS’ ADVOCATES IN THE 1990s

Changing Debates and New Debaters

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Birth

Abstract

Beginning in the 1960s, the maternity patients’ movement in the United States was joined by lay, medical, and political critics who protested the escalating cost, poor and inequitable distribution, and overspecialization of medical care. During the 1970s some goals of the maternity patients’ movement were met, including fathers’ attendance at birth, care in low intervention birth centers, and keeping the newborn baby with the parents immediately after delivery. At the same time, however, perinatal care became ever more based on new technology, tests, and procedures, some of which were promoted by doctor-developers in continuing education courses and in expert witness testimony at malpractice trials. Primary obstetric units closed while urban and suburban centers advertised new services to people who could pay. In the 1990s the maternity patients’ advocates have most of the same complaints as in 1970, as well as many new ones.

These are strange times for maternity patients’ advocates and those who campaign for the benefit of all patients in the United States. From its heyday in the mid-1970s, the maternity and newborn “consumer” movement has felt oddly labeled. Who, after all, is the consumer when a medication or procedure is ordered, if not the person ordering it? In fact, obstetric prescriptions often benefit the prescriber more than the patient. Cesarean section, for example, is increasingly understood as one of several physician responses to a hectic schedule or to fears of malpractice litigation (8;49). Medication for pain in labor is now occasionally acknowledged as a substitute for bedside nursing support (30), and electronic fetal monitoring has been seen as conferring more status and legal protection to practitioners than does auscultation (64). Many tests and procedures used in perinatal care benefit those ordering them. Such benefits include enhancing job satisfaction, enabling the use of more complex skills, protecting practitioners from litigation, and increasing revenue. Perhaps it is more accurate, therefore, to call members of the perinatal caregiving professions “consumers” as well as “consumer advocates.”
ISSUES OF MATERNITY PATIENTS’ ADVOCATES

Until the mid-1970s, the maternity patients’ movement called for caution in the use of perinatal interventions, for better studies of safety and efficacy (and normal birth), and for modification of practice in light of the results of good clinical trials. The patients’ movement also called for the use of low-cost, human, and low-technology medicine before resorting to diagnostic tests, hospitalization, drugs, or maternal or neonatal intensive care. The specific list of objections to hospital obstetrics was derived mainly from observations of home births. Patients wanted fathers to be able to stay with mothers during labor and delivery; a skilled labor companion (doula or monitrice); little or no pain medication in favor of emotional support; no shaving, oxytocin, or electronic fetal monitoring; a leisurely delivery without fundal pressure, with the mother in a standing, squatting, or reclining position as desired; no routine episiotomy; no routine care of the infant, including ophthalmic prophylaxis; immediate and on-demand breastfeeding; continuous company of infant and parents; no routine nursery care of the infant; only religious or medically indicated circumcision of male babies; and discharge home within hours of delivery unless contraindicated (15;38;65).

The wishes of these patients conflicted sharply with common obstetric and neonatal practices in the 1970s, although some obstetricians who catered to well-educated women did make concessions as the birth rate fell to the lowest point ever recorded in the United States in 1974. Such doctors used less narcotic, sedative, and tranquilizing medication. Spinal, caudal, and pudendal blocks gave way to epidural anesthesia. Some obstetricians became comfortable with fathers watching them.

Other obstetricians did not woo patients, especially those who served mostly poor women. In some of those settings patient care resembled that of 25 years earlier, as described by Shaw in *Forced Labor* (60) and Arms in *Immaculate Deception* (2), both published in the mid-1970s. Observing obstetric practices in the northeast, east, and western United States, these authors saw unattended women laboring several in a room, under twilight sleep amnesia–analgesia, being examined internally without regard for privacy, restrained, shouted at, given spinal anesthesia, and sometimes left to wait until a doctor could help them deliver.

The maternity patients’ movement entered the 1970s joined by a nationwide outcry against medical practice in the United States. The January 1970 *Business Week* (72) lead story, titled “The $60 Billion Crisis,” rated American medicine inferior to national health services in European countries, while the January 1970 issue of *Fortune* (73) had a lead article, “It’s Time to Operate,” which read in part:

Much of United States medical care, particularly the everyday business of preventing and treating routine illnesses, is inferior in quality, wastefully dispensed, and inequitably financed. Medical manpower and facilities are so mal-distributed that large segments of the population especially the urban poor and those in rural areas, get virtually no care at all—even though their illnesses are more numerous and, in a medical sense, often easy to cure.

The United States government responded to the maldistribution and high cost of obstetricians by giving financial and other incentives for the training and practice of a variety of primary care providers, including family physicians, nurse-midwives, physicians’ assistants, and nurse practitioners, all of whom delivered babies in certain settings. Feminists, who had gained attention publicizing the misogynist attitudes conveyed in some obstetrics and gynecology textbooks (59), had started abortion and gynecology clinics in many large cities (7). In this period over 50 nursing texts and articles were written on the nurse as a patient advocate (71). Several national home
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Birth organizations were founded, all with physicians among the members, with one exclusively for physicians (61).

ISSUES REMAINING FROM THE 1980s

Despite this nationwide and sustained (albeit disorganized) lay and professional movement, a decade later all of the major advocacy issues have grown in magnitude. Obstetricians and obstetric units have increasingly relocated from rural and inner city areas, where more poor and high-risk women live, to suburban and urban perinatal high-risk centers. Using public relations firms and business managers, perinatal specialists, societies, and journals have joined with commercial medical suppliers, or have become corporate owners and suppliers of equipment and techniques. Growing numbers of perinatologists now refer to their work as "marketing products," not care, to "customers," not patients (12). Hospital perinatal centers now market their capabilities, not only to the public, but also to community obstetricians, reminding them that referring patients to the perinatal center lowers their malpractice liability (36).

In this climate, rates of most obstetric procedures have increased, except those that have been replaced by more advanced or costly alternatives, as, for example, the use of forceps in some settings has given way to cesarean section (70). Myriad new technologies have become "standards of care" before benefits and risks have been investigated, usually after continuing education presentations by perinatologists, but sometimes on the basis of expert testimony by perinatologists during malpractice lawsuits (57;74). Cesarean section rates have risen from 4% in 1969 to over 25% in 1989 (43). The cost of a vaginal birth rose from about $1,000 in 1979 to between $3,000 and $5,000 in 1989, depending on the number and types of antepartum and intrapartum procedures done. Obstetric practice by primary caregivers, as well as by community-based obstetricians, has declined, largely due to restrictions on their practice from the threat of malpractice lawsuits (23) and very high insurance premiums (75). The malpractice insurance companies that levy these premiums are nearly all owned or controlled by professional societies or affiliated hospital systems (50;62), who decide which practitioners to insure and whether lawsuits will be settled by payment to patients or defended in court.

Some advocacy issues have lessened in magnitude. Circumcision rates have declined (40), as have rates of pubic shaving, the use of stirrups during delivery, and episiotomy in some settings (53). Of 41,000 family physicians, 10,600 still practice obstetrics, about 2,000 nurse-midwives practice, and about 135 freestanding birth centers still provide perinatal care.

In addition, three of the major goals of the maternity patients' movement in the 1970s have been met, but with mixed benefits to patients:

1. Fathers are almost uniformly admitted to births. This has opened maternity care to public inspection. But it is seldom recognized that, during labor and delivery, fathers are patients, too. They are liable to feelings of terror and inadequacy as labor intensifies, and are sometimes more eager to resort to drugs and surgery than are nurses and doctors (47).

2. Birth centers that were opened in hospitals in order to attract paying patients have gradually become labor-delivery-recovery rooms (LDRs) because these require less space, staff, equipment, and moving of patients (14). But many patients would like more nursing care and less cramped, high-technology, assembly line obstetrics. And, although LDRs are often called "birth rooms" in hospital advertising, they are no longer low-intervention sites. Epidural and systemic pain medication, oxytocin, electronic fetal monitoring (EFM), and labor and delivery in the recumbent position are the rule.
3. Bonding, first described as immediate, continued, and private contact between parents and newborn infants has now become a charade in which the baby is merely held for a few minutes by the parents before being taken to the nursery for routine care (34).

Since 1980, the lay component of the patients' movement has diminished to single-issue groups such as those advocating the end of routine circumcision and reductions in cesarean rates (13). Both groups are quite effective. Recently, legislation was passed in New York and Massachusetts that compels hospitals to make public their obstetric intervention rates, including surgical delivery rates. Physician groups are also working to lower cesarean rates (18).

Similar narrowing of interests and dwindling of numbers has occurred among doctors and nurses who were patient advocates, so that in 1990 there is no longer a maternity patients' movement, but rather individual researchers and research groups who design evaluations of care. The way such trials affect patient care (or fail to affect it), whether trials are carried out or get published, or whether (and to whom) clinical or population data are made available have become economic and political issues rather than scientific or public health issues. Thus, the discussion that follows is of the economic and political uses to which perinatal innovations have been put since 1970, and the issues that may emerge in the 1990s based on experience in the United States.

ABANDONMENT OF PRIMARY PERINATAL CARE

Starting in 1970, the maternity patients' movement was opposed by a much better organized and financed movement, that of obstetricians who were developing maternal–fetal intensive care. This idea derived from two innovations. The first was regional transport and referral programs started in the mid-1960s. A typical program was North Carolina's system whereby the state was divided into six regions, each with eight primary maternity units (Level I units) that referred high-risk pregnant women and neonates to two Level II units where all neonatal intensive care except respiratory support could be provided, or to one Level III unit where the full range of intensive care was available (4). By 1970 this regional program and similar ones in Arizona (19), Nevada (21), Cleveland (39), and Quebec (67) were reporting lower perinatal mortality, primarily among some preterm babies and those affected by maternal diabetes and rhesus hemolytic disease, compared with rates in control regions matched by population characteristics.

The second innovation bearing on the development of maternal–fetal intensive care was electronic fetal monitoring (31). Starting in 1972, some medical school obstetric departments, in partnership with the growing number of new electronic monitor companies (35), began to publicize their “maternal-fetal intensive care units” (51) where all laboring women could not only be electronically monitored, but also could be provided with an array of antepartum and intrapartum tests and procedures.

These two innovations seemed to offer both obstetricians and patients' advocates what they wanted. With a ratio of about eight primary to two secondary and one tertiary maternity unit, normal childbirth care would flourish where it was already offered, and would be developed in the rural and inner cities where it was sparse. Any subsidies would have to cover only Level I equipment and staff and their training in prenatal risk identification. On the other hand, referral of high-risk women and newborns would slow the falling occupancies in university centers, which since 1964 had struggled to attract new medical graduates to the specialty (29) in the face of declining birth rates and the flight of middle-class families to the suburbs (16).

After 1972, however, the regional perinatal programs faded into isolated experi-
ments, the results of which filtered into the general medical literature for a decade (26), whereas the perinatology specialty groups published a new “standard of care” for staffing and equipping obstetric units for maternal–fetal intensive care. The first pages of this publication stated that all Level I maternity units should close or consolidate with others in order to achieve the occupancy that would finance specialized staff and equipment for perinatal intensive care (56). In lobbying legislators and speaking to physicians and community groups, proponents of consolidation referred to it as “regionalized perinatal care” and showed slides from the regional perinatal projects (54). Research was cited to show that small maternity units were unsafe (69) and conflicting evidence was ignored (26;22). Because most small hospitals were in rural or poor inner-city areas, resistance to closures was weak. In Massachusetts, for example, where live births decreased 24% between 1970 and 1975 (twice the national average), maternity units dwindled from 120 to 63 between 1960 and 1975, and by 1977 the only Level I unit in the state was on the wealthy island of Martha’s Vineyard (55).

Thus, the 1976 standard eliminated the central component of regional perinatal plans: referral and transport of high-risk women and newborns from rural and inner-city small obstetric units. Those patients, although commonly poor and at risk, had to travel greater distances, sometimes over snowbound terrain or through dangerous ghettos on public transit, to county hospitals or to the remaining Level II or III units, where they could be refused care if they had public assistance, such as Medicaid, or no insurance (52). By consolidating obstetric units, the high cost and diminishing availability of perinatal services in the United States was worsened at a time when nearly all other developed countries were regionalizing obstetric care so as to serve both normal and high-risk women more easily and at lower cost (68).

This will be an increasingly critical issue in the 1990s, because local projects set up to replace the small maternity units have not filled the need. Storefront clinics and projects in ethnic neighborhoods have been poorly and intermittently funded, and have not restored the neighborhood doctors’ offices, pharmacies, and ancillary services that disappeared along with the small maternity units. Simultaneously, the last decade has seen a skyrocketing need for low-cost, neighborhood maternity care in cities, due to migration from rural areas, immigration from developing countries, rising levels of poverty, and increasing numbers of previously insured people, that is, the “medically indigent.”

ENCOURAGING COMMUNITY HOSPITAL REFERRALS TO PERINATAL CENTERS

Although closing small maternity units stopped referrals of high-risk poor women from them, referrals from larger suburban hospitals and local practitioners to perinatal centers were encouraged in the 1976 publication of standards. Community obstetricians at Level II hospitals resisted referring women because they did not wish to relinquish patients, especially in a period of record low birth rates. The least understood debates that are likely to be heard in the 1990s have evolved from the ways in which community obstetricians have been encouraged to refer pregnant women to Level III perinatal centers.

CONTINUING EDUCATION

The January 1984 issue of Contemporary Ob/Gyn featured an article by Alex Levering (36) titled “Planning Ahead to Keep Your Perinatal Center from Falling Behind.” He explained how Long Beach Memorial/Women’s Hospital finances their perinatal center
“with revenue derived from patients.” The center uses “perinatal outreach.” A team that consists of a neonatologist, a perinatologist, and nurses speaks to staff at community hospitals about their “enlightened self-interest” in referring patients to the high-risk center: it reduces malpractice liability. “While we view outreach programs as a marketing tool, we talk to . . . medical staff solely in terms of education, consultation, and service” (36).

This marketing tool, masquerading as education, consultation, and service, is one of thousands of continuing education programs sponsored by perinatal centers and the drug and equipment companies that supply the centers. The programs are attended by nurses and doctors, in part to fulfill periodic relicensing requirements. Among American perinatal caregivers, continuing education meetings have become more influential than peer-reviewed journals in disseminating new procedures, as well as fostering a climate of uncritical acceptance and consent. Some of the reasons are:

- medical staff are required to attend a certain minimum of such programs, but are not required to read journals;
- meetings are often free to the registrant, having been paid for by companies or hospitals;
- medical staff get time off for conferences, while reading journals must be done on personal time;
- innovations reach practitioners sooner at meetings than in journals;
- conference papers do not undergo prior peer review, in contrast to journal articles, which have become so numerous and complex as to stymie the average physician reader; conference papers have become less complex, and they are often sprinkled with entertaining slides and mixed with vacation and social functions;
- listeners are prey to inordinate influence by speakers with authority, power, or acting skill (44);
- in the United States there is no tradition of disputation whereby speakers with dissenting views are welcomed at the microphone and their ideas given a fair hearing; and
- those with conflicting views or evidence may decline to speak from fear of loss of promotion, funding, access to data, or publishing opportunities.

**ELECTRONIC FETAL MONITORING AND ULTRASOUND IMAGING**

It has been through such continuing education programs that EFM companies, ultrasound device suppliers, and hospitals that deployed the machines presented the advantages of EFM and fetal scanning to community doctors and nurses. Sometimes it has not been clear that speakers or sponsors at meetings are actually corporate equipment suppliers or doctors who receive research or development funds from commercial interests. So far, however, doctor and nurse audiences have not raised the important issue of conflict of interest between speakers’ products and their moral obligation to present the full range of (often conflicting) evidence, thus paving the way to more effective patient care. Instead, as Levering (36) stated, continuing education programs are marketing tools to sell caregivers on the need to refer patients to new programs, services, or personnel at perinatal centers or to sell products to caregiver “consumers.”

In the early 1970s, patients were referred to perinatal centers because the centers had the staff and equipment to electronically monitor fetuses, at first only during labor, and then in the late 1970s, during pregnancy. These centers were also rapidly acquiring staff and equipment for ultrasound imaging of the fetus. What objective evaluation should speakers have included in their presentations of these innovations? In the last half of the 1970s three randomized controlled trials (RCTs) had failed to find benefit from EFM in high-risk pregnancies, and by the mid-1980s these findings had been replicated several times, as reviewed in detail by Grant (24). Randomized controlled
trials of nonstress and contraction stress testing showed little overall benefit and high rates of false-positive tracing interpretations; the trials were analyzed thoroughly by Mohide and Keirse (41). Similarly, randomized controlled trials of routine ultrasound scanning have not led to any firm conclusions as to benefit, according to a complete review by Neilson and Grant (45).

Yet, in 1990 antepartum and intrapartum fetal monitors and ultrasound scanners are used routinely in all maternity units, and even in obstetricians' offices, although a survey by the American College of Obstetricians and Gynecologists showed that few obstetricians have adequate training in performing and interpreting scans, and 73.3% of scans are carried out by an employee (61). The medico-legal advantage of having monitor tracing and scan evidence is cited as one reason for this proliferation of complex technology. A shortage of nurses to do frequent auscultation in labor is also cited. Hospitals, doctors, and nurses may also prefer electronic monitoring and scanning over hands-on care because these procedures call on higher levels of technical skill and can be billed at higher rates than can auscultation. These four priorities amount to caring for caregivers — at considerable expense, some risk of overtreatment, and no evidence of benefit to patients. In fact, EFM and prenatal ultrasound scanning often begin a "cascade effect" of further diagnosis and treatment in labor and pregnancy, based not on clinical signs in the patient, but on equivocal or unusual readings of tracings and scans (42).

Two difficult challenges for the 1990s are to encourage practitioners to alter care in light of the results of well-controlled trials, and to better balance caregivers' comfort, incomes, and interests (job satisfaction) with effective patient care. Closely related to these is the need to raise the standards for continuing perinatal education, incorporating more of the objective information balance available in the literature into the content of conferences. This balance would be achieved by including review of all the relevant, well-designed clinical trials. Recent organized efforts to summarize these findings for clinicians (10) should make this task easier.

RISK ASSESSMENT AND REFERRAL

Risk assessment systems also provide a vehicle for referring women to tertiary care. Among over a dozen systems (1), some risk factors have become outmoded (primiparous maternal age >29; working mother) and other factors have gained vogue (psychological stress; previous termination of pregnancy; being unemployed; uterine "irritability" after 24 weeks). Practitioners who rigorously score all patients might find reason to refer over 50%.

But community practitioners have resisted referring all women with risk factors. First, the term "risk" is vague. A woman may be normal, but according to items on a risk list is "at risk of poor outcome" in Hobel et al.'s (28) system, or "at risk of need to transfer to tertiary care." Second, risk scoring is seldom accurate. Doctors and nurses omit many questions, especially social ones (25), and patients may not divulge such key factors as past abortions or drug use. Third, many practitioners resist referring women with risk factors to tertiary care because they realize that prevention or prophylaxis may be worse than the risk. For example, a woman referred for risk of preterm labor must travel to the perinatal center and prove she or her insurance will pay for care, only to be told to stay in bed, not have orgasms, not work or take care of her small children, and rent (for about $75 a day) a tocodynamometer belt that transmits uterine activity to the perinatal center. Trials that eliminate selection bias have not shown any reduction in preterm births from such heroic treatment (37).

One task for the 1990s is to assess properly (by RCTs) the value of formal risk
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assessment in unselected populations, and to separate it from cointerventions (1). This evaluation is of utmost importance in countries with national health services, where it is hoped that formal risk assessment might identify those who need more specialized care. In the United States most efforts beyond informal risk assessment are a middle-class luxury. Whether the resulting referrals to tertiary care do improve outcomes remains to be clarified.

PRIVATIZATION OF PROCEDURES AND DATA

A recently successful way to encourage referrals to perinatal centers has been for their staff to present courses on new technologies that, unlike EFM, are not intended for dissemination among community caregivers. Examples include home-hospital preterm labor monitoring (20), fetal diagnostic tests and therapies, genetic tests such as chorion villus sampling (66), and infertility treatments and devices (3). Some new techniques and equipment in these specialties are actually owned or patented by universities or perinatologists, whereas some doctors and laboratories have exclusive arrangements with hospitals, so that referral of patients who want those procedures is necessary. Besides issues of access to care and cost containment, there are more troubling debates over data collection and their use in evaluations of these procedures. Some corporate in-vitro fertilization ventures, for example, have withheld data and techniques from professional study, and have published misleadingly optimistic data on success rates (5).

PATIENT SELF-REFERRAL TO TERTIARY PERINATAL CARE

By far the most successful way perinatal centers recruit middle-class pregnant women is to encourage them to refer themselves. In the September 29, 1984, San Francisco Chronicle, David Perlman reported on a conference titled “Learn to Play Hardball” where hospital administrators were told how to advertise their emergency rooms, birth rooms, and open-heart surgery services, all of which are used predominantly by the wealthy, or are highly paid for by insurance. Increasingly in the 1980s the popular media described “miracle babies” from in-vitro fertilization, home-to-hospital preterm labor monitoring, new fetal surgeries and newborn transplants, and other dramatic perinatal “breakthroughs.” Hospitals mail regular newsletters to the high- and middle-income postal code zones in their areas announcing the same range of perinatal innovations. Editors of both lay and medical publications receive news releases and offers of “research” from public relations firms every day; their clients are medical organizations, hospital suppliers, and individual doctors who, for example, “will be in your area and available for an interview about his groundbreaking research.”

Perinatologist Ronald Chez (12) wrote in the March/April 1984 issue of Perinatology/Neonatology that “Marketing in medicine has become respectable.” He cautioned that today’s health care system, which emphasizes competition between providers and limitation of health care costs,

... requires health care providers to take advantage of proven marketing tools to solve problems of market share, market position, product differentiation, customer base expansion and maintenance, and new product development. (12)

For the United States, the most pressing issue in the 1990s should be to reassert the higher technical and ethical standards that distinguish medicine from marketing, standards that, in fact, underlie medicine’s favored treatment by society. “Customer base expansion” drives up already staggering medical costs. “Product development”
is not medical care. Patients are not "customers." Customers can usually judge whether they need an item and its quality. They are under no pressure to buy, and they can return the goods if they are not satisfied. In contrast, few patients have any basis on which to judge the quality or utility of medical advice or care. Patients are under some pressure to agree with their doctor and they cannot return the goods.

THE THREAT OF A MALPRACTICE LAWSUIT

The least discussed, most powerful way that community practitioners are encouraged to refer patients to tertiary care is the expert witness system in malpractice litigation. All doctors, nurses, and midwives know that if they or their institutions are sued for malpractice by parents of a child who dies or is diagnosed as having cerebral palsy or mental retardation, the attorneys for both sides have access to catalogs of perinatologists who are paid to travel the country and testify to the efficacy of procedures with which they are most familiar. An obstetrician and hospital that have incorporated the innovations recommended by the academic perinatal community have less to fear from expert-witness testimony than do more independently minded people or primary caregivers outside the obstetrics and gynecology specialty.

Another safeguard for obstetric caregivers is malpractice insurance. Nearly all the insurance companies are owned or controlled by hospital groups or physician specialty organizations (50). Although this ownership evolved to control rising premium costs during the "malpractice crisis" of the mid-1970s, the doctor-controlled companies have discovered that limiting insurance coverage to certain types of care and facilities is a powerful tool for controlling who delivers babies, where, and how. For example, raising premiums or denying coverage for certain types of care has been used to curtail the practice of both nurse-midwives and family physicians (23). Withholding legal defense in case of lawsuit (settling out of court on monetary awards) is also used to control the actions of the practitioners (9).

Hospitals have their own "risk management" programs, often run by representatives of insurance companies affiliated with the institution. These are usually doctors or lawyers who are known as risk managers or quality assurance directors who monitor all hospital staff activities with an eye to potential lawsuits. They give lectures on what can and cannot be defended in court, based on courtroom testimony. The general belief is that using EFM and timely resort to cesarean section, along with all pertinent tests and procedures earlier in pregnancy, will probably prevent most cerebral palsy and mental retardation (57). If not, such care will, at least, be defensible in the courtroom.

This chilling process may receive greater discussion in the 1990s because obstetric malpractice lawsuits are becoming more frequent outside the United States (11). American parents of children who need lifetime medical and social services are rarely able to afford that care without very large awards from malpractice lawsuits. Most such lawsuits fail (58), but the rare high monetary awards get wide news coverage.

In the United States a key issue in the 1990s is how to organize more equitable payment for the care of those born with malformations, including cerebral palsy and mental retardation. A second key issue is reform of the medical malpractice system, perhaps along the lines of those in New Zealand (6) or Sweden (48). For the international prenatal community a pressing issue is to settle whether and to what extent perinatal care can prevent or ameliorate malformations such as cerebral palsy and mental retardation, as well as attendant problems of perinatal mortality, low birthweight, preterm birth, and intrauterine growth retardation (33).
WHAT PERINATAL CARE SHOULD DO; WHAT IT CANNOT DO

The loudest cry among Americans regarding medical care in general, and perinatal care in particular, is for lower costs; reorganization of doctors and hospitals to increase sites and practitioners of primary preventive care; fewer barriers, both social and financial, to obtaining perinatal care by poor women; and less overuse of tests, technology, and surgery. These are the same goals sought in 1970, when the United States had a lower proportion of poor people and when medicine consumed a smaller proportion of the gross national product. Thus, one must conclude that to advance toward these goals will require more than the present systems of peer review and quality assurance. It will require very broad changes in governmental policy and control, since what has evolved without such oversight is costly forms of perinatal care provided to those who can pay, with limited access to people who cannot.

Even if perinatal care were free and easily available to all in the United States, it should not be expected to remedy a growing number of ills that are not medical, but social problems that compromise healthy childbearing: low socioeconomic status; alcohol, cigarette, and drug addiction; sexually transmitted diseases; childbearing at very young ages; battering and sexual abuse; and homelessness.

The final issue that remains with us into the 1990s has also been raised during the care of these most socially deprived women. That is the issue of forced care, usually cesarean section, and usually after a bedside hearing before a judge (17), but also by obstetricians acting on their own (32). Fetal abuse has been charged, and jail ordered, for women who did not follow doctor's orders and for pregnant women who did not attend drug treatment programs (46). The issue is whether women can be forced to undergo treatment for the sake of their unborn children. Legal arguments aside, one question is how perinatal caregivers can best act as fetal advocates: by pitting themselves against a pregnant woman's wish to refuse recommended care, or by joining together to organize a lower cost, more easily available perinatal care to a nation of women and fetuses.

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