

## MEDIA REVIEWS

### **The Medical Delivery Business: Health Reform, Childbirth, and the Economic Order**

*Barbara Bridgman Perkins*  
*Rutgers University Press*  
*New Brunswick, New Jersey, 2004*  
 252 pp, \$42.95, hb

In this *must-read* book, health care consultant and independent scholar Barbara Perkins reveals the economic underpinnings of medical care and urges readers to take seriously the business aspect of medicine. She documents how the gradual “corporatization” of medicine in the United States has drastically affected perinatal care in the 20th century. The corporate structure of hospital management and services, medical specialization, continual need for operational funds, and corresponding production and marketing models of maternity care have led to routine use of excessive interventions during childbirth and in neonatal intensive care units (NICUs). These developments all help explain why obstetrical procedures evolved and continue to be widely used despite insufficient evidence of their efficacy. One most important theme is that the prevailing business imperatives underlying medical care define, determine, and distort that care. This brief review risks oversimplification, however, and cannot do justice to the complexity and subtlety of Perkins’ discussion.

The book has three main parts. The first, “Medical Specialism and Early-Twentieth-Century Economic Organization,” describes how 20th century managerial theory encouraged development of industrial-type organizations for institutions, requiring concentration of work and services in large plants, labor specialization, standardization of process, and monopolization of technology. This economic model emphasized efficiency, uniformity, control, and market competition for trade among hospitals and physicians. It brought the realms of financial management and medicine together, creating a new definition of “science.”

The evolution of 20th century obstetrics illustrates that when science, business, and medical practice intertwine, business imperatives overwhelmingly affect clinical attitudes and practice. Childbearing

women, especially wealthier women, became the “consumers” providing the bread-and-butter income of many hospitals. As a result of complex social, economic, and scientific factors, hospitals merged with medical schools. Academic and medical specialties had to compete with each other for needed departmental funding. For the surgical subspecialty of obstetrics/gynecology to achieve full departmental status in medicine, obstetrician-gynecologists were obliged to distinguish their area of expertise from that of general practitioners and midwives. Thus, they promoted routine use of obstetrical procedures originally devised to treat complications. Attending normal births did not confer professional prestige, so treating birth as a “pathological” process needing obstetrical assistance became common practice and evolved into a strategy for professional advancement.

Standardized business models had profound and lasting clinical effects. As hospitalization for childbearing women increased to supply a “continuous operational flow” of women, some physicians did not allow labors to run their natural course, but speeded them up with pituitary extract despite its unpredictable results. Physicians advertised their services by using and perfecting specialized techniques (forceps, episiotomy) to enhance their reputations, solidifying their grasp on that particular intervention. In addition, to ensure maximum efficiency along factory-type lines, a division of labor and a hierarchy of workers led to a sequence of technical procedures performed in a sequence of work stations staffed by differently ranked practitioners with various degrees of power within the system. Such fragmentation of care determined the actual architectural style of hospitals. It divided the continuous process of childbirth into “labor” and “delivery,” and labor into three “stages.” It required separate rooms (intake, labor, and delivery) for each function and staff level (sometimes women were moved as often as *six* times).

Additional examples make it clear that business imperatives are not simply neutral tools enhancing efficiency, but end up embodied in practices that impinge on the natural unfolding of labor, changing its very nature. So-called obstetrical “science” developed into standard medical practice. It shaped both the attitudes of childbearing women and the

education of their practitioners, eventually leading to the present fragmented view of birth. (Perkins argues that this circularity must be broken *not* by changes in attitudes, but by changes in actual practice.)

The second part, "Designing Delivery Systems," describes the growth of academic medical institutions in size and scope, necessitating more revenue-generating services and cost controls. In the late 1920s, medical care leaders from many fields met to form a Committee on the Costs of Medical Care. Its final report envisioned that hospitals would develop into comprehensive groups organized as community medical centers, allowing physicians and hospitals to maximize personal and institutional revenues and "socialize" the costs of production. During the 1970s and 1980s, health planners and hospital administrators developed the concept of regionalization, which designated primary, secondary, and tertiary levels of care, consolidating medical services and allocating target markets.

Although Perkins sees regionalization's capacity to transfer the births of very low-birthweight babies to NICUs in level III hospitals as beneficial, she questions its goals and value for the *majority* of women and babies. Since level III hospitals command the most expensive technology requiring technical expertise, the system tends to restrict competition by more low-key family medical services. Requiring more patients to cover high overhead and operational costs, it markets specialized services to women and babies whether needed or not. With the birth "market" consigned to specialists, the system escalates perceived standards for obstetrical services. Thus, large-scale delivery units become the legal standard of care. Despite ever-expanding tertiary care facilities, perinatal health status nationwide has improved little.

The third part, "The Economic Production of Childbirth," discusses professional competition for the birth market, capital intensive medicine in the guise of NICUs and electronic fetal monitoring, evolution of managed care, and active management of labor. In 1973, births in the U.S. were at their lowest point. Obstetrician/gynecologists, threatened by family practices, expansion of midwifery, and creation of free-standing birth centers (truly innovative institutions), needed to protect and enlarge their clientele. They had competitive advantages over general practitioners by dint of hospital privileges and their command of surgical and technological procedures. All too often they suppressed midwifery practice or absorbed nurse-midwives into private, group, or hospital practices, medicalizing midwifery art and craft. Independent birthing centers, needing backup hospital care, operated with fairly restrictive protocols, or were equally absorbed into hospitals as "alternative birthing centers." Here, oddly enough, interventional intensity often escalated while labor and delivery became more family-centered and humane.

Perkins sees NICUs as providing a primary rationale for the three-level regional system and serving a strategy that fitted hospitals' economic goals. NICU nurses perform at a high level of technological responsibility and capability, and in fact, challenge the medical hierarchy. However, this expensive, profitable, high-intensity technology can lead to invasive techniques and unnecessary overtreatment of newborns. It is devised to attend to babies' short-term survival, but not to their long-range health concerns after discharge, nor to any underlying socioeconomic conditions. Many hospitals with NICUs tend to admit even healthy babies to offset costs of really high-risk cases.

Managed care is the ultimate corporatization of medicine. It standardizes clinical "production" by establishing practice guidelines and clinical protocols, with Diagnostic Research Groups (DRGs) determining the highest revenues from each medical condition—all aimed at increased productivity and profitability. Each DRG represents a package of standardized practices. For example, use of oxytocin is a component of clinical managed care, reducing labor to a series of steps in a production process, using cervical dilation rates to schedule labor intervention, with no truly scientific evidence of benefits to mothers and babies. In the 1980s and 1990s, with the advent of managed care, it was also seen as a way of saving millions of dollars by shortening labors and reducing cesarean section rates. (One might plausibly conclude that the cesarean section rate is rising in the early 21st century because hospitals now need the increased revenue cesareans provide.)

Perkins concludes that medical care in the 20th century was not designed to meet all peoples' health needs; that medical ethics were based on acquiring wealth and power rather than assuring health; that "public interest" and a free-market approach were skewed toward wealthy people and avoided collective responsibility for community health. When maximizing profits becomes the driving cause of medical reform, it may be incompatible with peoples' health needs. True reform requires planning (anathema to free market ideology), involving equal coverage for all. It would probably require a single payer system, budgeted so that it would not have to sell its services, with funding allocation priorities democratically achieved.

For childbearing women, Perkins advocates health promotion, primary care facilities where midwives are primary caregivers, and independent birthing centers. Personnel, institutions, and equipment would have to be quantified and redistributed to match service intensity levels, based on best available estimates of efficacy and need. She recognizes, however, that the hegemony and momentum of the present medical system and economic order make it difficult (an understatement!) to develop realistic alternatives.

I recommend this book highly. It is weighty reading, but worth it. Dense, precise, well researched, and copiously documented, it offers a rich discussion. For 35 years I have written about childbirth, critiqued childbearing advice books, and advocated for maternity care reform, but I have paid little enough attention to the issue of medical economics or the corporatization of health care. Clearly, especially in the domain of obstetrics, the marketplace and influence of professional power determine the structure and direction of medical care, and affect all childbearing women. To understand the forces that prevent the creation of a truly woman-oriented system of maternity care, we (health providers, childbirth activists, educators, social scientists, and other maternity care reformers) must take economics into account.

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## **Understanding Birth: A Comprehensive Guide**

*InJoy Videos Boulder, CO, 2001*  
*www.injoyvideos.com*  
*148 min, VHS & DVD, English and Spanish*  
*\$395*

*Understanding Birth* was designed for educators to present short video segments followed by interactive discussion in their childbirth classes. Topics are divided into nine chapters, with clear divisions so the educator can locate easily the segment needed for that class. This video is informative and empowering overall, representing normal birth, parenting, and breastfeeding. The educator will need to add information or elaborate on some topics in a few areas that need more evidence-based information.

Most chapters last less than 15 minutes, and the three longest chapters are “Understanding Comfort Measures,” “Understanding Interventions,” and “Labor Preparation Exercises.” Each chapter contains a mix of information, visual images of parents in mostly normal birth situations, graphic images showing how the body works and the baby descends, and personal stories and comments by parents who have graciously allowed their births to be photographed.

“Understanding Pregnancy” focuses on issues related to the third trimester. I was pleased to see current information on preterm labor prevention and symptoms, and emotional and physical changes, birth dreams, nutrition, and exercise are well covered. It would have been better to give instruction on tim-

ing contractions in the next chapter, however, since distraction during early labor is far more important than concentration on timing contractions. In their discussions, educators will need to include support systems for childbearing families, harm from second-hand smoke, consuming alcohol and nonprescribed medications, and forward-leaning positions to help move the fetus from a posterior position.

“Understanding Labor” begins with images of a mother eating and drinking at home surrounded by loving continuous family support. The producers respect the language of normal birth. The movement from early to active labor is presented by using terminology describing contractions as “warm-up” or labor. Good continuous physical and emotional support, upright positions for labor and birth, and the emotions of labor—both verbal and visual—make this a good section for stimulating discussion in class. These birth scenes are a dramatic improvement over many of today’s television portrayal of traumatic and dramatic births. Parents will appreciate seeing what real birth is like.

Deborah and Jeff let us walk with them through their birth. We have seen them before in the Lamaze International’s video, “Celebrate Birth,” and it is fun to hear them tell their complete birth story. In early labor we see them getting a bite to eat in a restaurant, leaning on each other during a contraction in the park, and deciding it is time to go to a safe and quiet place to continue their birth journey. They are joined by their doula at the hospital and use position changes, hydrotherapy with a Doppler, and lots of strong encouragement to give birth. The father’s role is clearer as Deborah talks about how much Jeff’s support got her through the fatigue of a long labor. Finally, spontaneous pushing with encouragement brings Aliyah into loving arms.

“Understanding Comfort Techniques” shows women using mind and body behavior, such as vocalization, continuous support, personal breathing techniques, upright and moving positions, and massage. It is helpful to hear the mothers describe their pain in realistic terms and to see the tranquilizing effects of endorphins. Jeff reminds fathers to listen to the mothers. The video shows back-labor techniques, such as counter pressure, double-hip squeeze, intradermal water block, squatting, lunging, and pelvic tilts. Pushing techniques include upright positions, massage with oil, warm compresses to the perineum, and upright positions. However, the mother giving birth is on her back while these options are presented.

“Understanding Interventions” introduced a few problems for me. The interventions were not always presented with alternative nonmedical options. Beginning with induction, prostaglandin and Pitocin are the only methods described and a quick summary of the methods of delivery for prostaglandin are as a gel on the cervix, tampon, or pill. The pill the video mentions so casually is Cytotec, which is highly

controversial, and despite permission by the American College of Obstetricians and Gynecologists (ACOG) for use in induction, Searle still distributes information warning against its use in pregnancy or birth. After viewing this chapter, I would also discuss nonpharmacological methods of induction and heparin locks as an option for medications. Julie used butorphanol tartrate (Stadol) in labor until she was 4 centimeters dilated and able to receive her planned epidural. The video does recommend late and light epidurals and laboring down. Side effects of vacuum extraction and forceps are only lightly presented as well as the side effects for episiotomy.

I really like the title of the next chapter, "Understanding Cesarean Birth," instead of using the age-old term "cesarean section." In many instances the video producers really paid attention to language that empowers rather than frightens parents. It would have been preferable to have portrayed an induction that was not for macrosomia, since it is not a recommended indication by ACOG or research evidence. I do realize, however, how hard it is to obtain births for use in videos. Educators will need to elaborate on the topic of medical versus nonmedical reasons for induction. This chapter also shows a sign language translator in the hospital, parents happy with their decisions for interventions, and breastfeeding and emotional support after cesarean birth. At the very end of the chapter are recommendations for reducing the risk of cesarean birth.

"Understanding the Newborn" is very well presented as an introduction to the latest information on infant cues, infant stimulation, capacity of the newborn to communicate, and nonseparation of mother and baby. I question whether suctioning a newborn born from a normal birth requires even mouth suctioning and suggest including that in a class discussion. Breastfeeding soon after birth, skin-to-skin contact for infant and parents, newborn procedures after birth, and informed refusal (although not stated that way) are quickly touched on and offer the opportunity for further class discussion. Physical characteristics and states of consciousness receive brief mention, and overstimulation, disengagement cues, and the myth of spoiled infants are seldom found in informational videos.

"Understanding Postpartum" presents remedies for possible physical experiences after birth, normal

physical changes, and warning signs to report to a mother's caregiver. Exclusive breastfeeding is recommended here and throughout the video, and hunger cues are shown. A nonthreatening short discussion of sex after birth is well done.

"Labor Preparation Exercises" is the longest chapter and may well be intended for home practice. Viewers not only learn about many positions but see women working with their labor in these positions. Pauses in the video allow viewers to stop and practice what they have just seen. One especially nice touch is having the mother and father trade places for the touch relaxation exercise to emphasize the importance of relaxation for life and for the whole family. There are no pauses in the visualization exercise to distract from the process. In the interests of time, however, visualizations are rather quick and educators might want to emulate the calming style and words to present visualization exercises themselves rather than relying on the video. Breathing exercises combined with positions, vocalization, and hand direction by the father are well demonstrated. Educators should remind parents that when labor begins, they may find these techniques helpful or they may want to just breathe normally.

Overall, this video's attention to normal birth and breastfeeding makes *Understanding Birth* an excellent educational tool that can be used in several ways. Parents who miss a class could view the topics at home and discuss them later with the instructor. For mothers on a bedrest regimen, this video could provide homework in preparation for private instruction. Educators could also develop their own interactive teaching ideas for each chapter. Its current price makes it unsuitable for placing in a lending library, but if priced lower, it would be valuable for that purpose. The settings for birth are all hospital based, but Injoy Videos has used its normal birth, breastfeeding, and parenting resources well and developed a video that will be extremely helpful to childbirth educators, doulas, and medical practices.

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