

BIRTHING CENTERS AND HOSPICES: RECLAIMING BIRTH AND DEATH

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Roslyn Lindheim

Department of Architecture, College of Environmental Design, University
of California, Berkeley, California 94702

INTRODUCTION

In pre-industrial societies birth and death were essentially social affairs involving cultural traditions developed over centuries. They took place in clan, tribe, or other familial group, supported by families and neighbors. In the United States, only two generations ago, most people gave birth at home and died at home, most often in the bosoms of their families. Today in the United States, 95% of births take place in hospitals and over 70% of deaths take place in nursing homes and hospitals (1, 2).

Two factors resulted in people transferring their control and management of the natural processes of life to the hospital and nursing home. First was the breakup of the extended family, with increasing urbanization and the necessity for institutional substitutes to care for the sick, the aged, the dying, and those being born. Second was the emerging belief in the power of science and the development of medical care. The belief was in the promise, on the one hand, of a painless and safe birth, and, on the other, in the power to prolong life.

The locating of birth and death in hospital environments removed them from the realm of family responsibility and generational knowledge; it identified them as pathological functions placed under the domination and control of the medical profession. Indeed, as rites of passage became enclosed within hospital walls, medicine took on much of the power formerly attributed to religion. Judgment about each new piece of medical knowledge or technology, as well as the efficacy of its application, became the domain of the expert. At the same time, the role of the family and other lay supporters in birth and death decisions were reduced.

The essence of the history of the hospital in the first 80 years of this century has been its use of an ever-increasing percentage of the health budget; the growth of specialization; and the medicalization of birth and death. Over the past two decades attempts have been made to reclaim some involvement in and individual control over life processes. Both home and alternative birth centers and hospices have developed in reaction to the dehumanization of these events within the hospital. These movements have, in turn, resulted in changes within the hospital. Nonetheless the major thrust is in the direction of larger and more centralized hospitals, increasing use of technology, and higher costs, which preempt budgetary support of alternatives to hospital-based care. These tendencies are coupled with the "hard sell" that anything less than the use of these facilities and their technologies is inferior care, exposing people to risks and making the users personally culpable.

The interaction of these trends, as they affect the development and current status of birthing centers and hospices, is the subject of this article.

PART I: BIRTHING CENTERS

The Childbirth Debate

There has been a growing polarization taking place in the United States around the issues pertaining to pregnancy, birth, and infant care. The polarization results from very different premises held about (a) birth as normal versus birth as pathogenic, (b) emphasis on preventive care versus end stage medical interventions, and (c) who has the right to decide, i.e. medical expertise as the sole authority as opposed to the desires, as they reflect community culture, of women and their families.

Within these major issues are further debates as to who delivers the baby, obstetrician or midwife, and whether the birth takes place at home, in hospital birth centers, small hospitals, or tertiary institutions.

While these issues are being debated, decisions are already being made and resources allocated that place birth and newborn infant care in the larger hospitals. Large sums of money are being spent on the development of neo-natal regional centers, which are justified by declaring all births as potentially "high risk" and requiring medical intervention. The assumption is made that the "so-called 'normal' patient is an entirely retrospective diagnosis that can only be made after mother and infant are discharged home in good health" (3).

Despite these trends, the number of voices advocating normal childbirth are growing, those of women, many in public health, primary health professionals, midwives, and consumer organizations. Advocates base their arguments on the facts that 75% of the childbirths in the United States are

normal, requiring no medical intervention (4); that women with normal pregnancies should have the right to choose nonhospital settings for birthing; that resources be allocated for nutritious diets, healthful living conditions, and easily accessible, careful, and concerned care. They believe that the issues concerning childbirth must be extended to include the conditions of life prior to conception, during pregnancy, and after birth.

High Risk—A Social or a Medical Problem?

One of the measures of the health status of a country is the statistics on infant mortality (babies who die in the first year of life). Despite increasing reliance on sophisticated technology, the United States ranks only fifteenth among industrial nations of the world (5, 6). There is great concern about these statistics; however, there is tremendous disagreement as to the most effective methods to reduce infant mortality, to insure the safety of mother and child, and to allocate resources. The identification and treatment of so-called "high risk" pregnancies and infant care has become a particularly controversial issue.

It is well known that the highest rates of infant mortality occur in minority and poor communities (7). They also have the highest rates of illness and social problems of all kinds (8), including the highest rates of teenage pregnancy and of premature deliveries. Many of the babies born are of low birth weight—the factor most identified with high infant mortality (9a). These communities have been classified as "high risk" as a social group, as have some other groups, such as diabetics, women with renal disease, and hypertensives.

A major question in the childbirth debate is how to best allocate resources to prevent and care for the above conditions. The technological approach advocates the establishment of more high risk obstetrical services and neonatal intensive care centers. This approach emphasizes successes in saving the lives of premature and low birth weight infants who previously would have died, as well as some successes in improving the condition of abnormalities at birth. Those who emphasize normal birth would focus on changing the environmental conditions that give rise to high infant mortality and morbidity in the first place.

Those most in favor of out-of-hospital birth do not say that IVs, electronic fetal monitoring, and other medical technology are intrinsically bad. They agree that these measures all have their place in a small percentage of cases and are sometimes beneficial. Indeed, advocates of home birth have estimated that 5 to 10% of mothers truly need hospital-based technological care, and another 20% need such care on a standby basis (9b). In Holland where there was a policy of the most careful screening, it was found that

70% of the pregnant women could safely deliver at home, a figure comparable to the above percentages (48).

Neither technological nor normal childbirth advocates argue over the hazard to a pregnant woman caused by air pollution, toxic wastes, excessive radiation, or about the value of a nutritious diet, sex education, birth control, and the avoidance of smoking, alcohol, and narcotics. Many on both sides would agree to the importance of other less obvious factors shown to affect susceptibility as well as resistance to diseases of all kinds—among them social networks and support systems (10)—and a sense of control over the conditions of one's life (11). Certainly in the case of minority women, discrimination, insecurity, relative poverty, distrust of those rendering care, and stress can affect the birth outcome. The difference lies not in the recognition of, but rather in the approach to these problems. Technologists generally dismiss social and economic issues as outside of their competence and expertise and hence rely only on technological interventions. Yet their very reliance on high technology and neo-natal centers diminishes the importance of other non-medical factors to the disadvantage of the overall well-being of the people in the community.

Startling results have been obtained by simple, low-cost innovations in the medical and social components of the birth environment. In Madera, California, a community largely comprised of so-called "high-risk" Black and Mexican-American farm workers and their wives, the introduction of sympathetic and competent nurse obstetric assistants had such impact that the neo-natal death rate decreased from 23.9 per 1000 live births to 10.3 per 1000 within a two-year period. The incidence of prematurity also declined, from 11 to 6.4% during the same demonstration period. When the project ended and the nurse obstetric assistants left, the neo-natal death rates and the prematurity rates returned to former levels.

What obviously affected the pregnancy outcome was the careful person-to-person attention, the concern for the mother, the visits to her house, and the confidence the mother felt in the nurse obstetric assistant (12–15).

Essential to any present-day decision making is an understanding of how normal birth became "the alternative" and "technological" birth the norm.

The Development of the American Birthplace

In 1900, only 5% of babies born in the United States were delivered in hospitals; by 1935, this figure had increased to 75%, and by the late 1960s, to 95% (1). This shift in birth from home to hospital began with the turn-of-the-century development of asepsis, anesthesia, and surgery. Prior to 1900, only the poor risked going to hospitals for any reason, birth included. Puerperal fever, associated with unhygienic physician and hospital practices, killed hundreds of women annually in maternity wards (16).

But with improvements in medical care, physicians started sending women from all social classes to the hospital for treatment of childbirth complications. The more cases hospital-based physicians saw, the more they characterized birth as pathologic rather than as a normal bodily process (17).

In 1920, Dr. Joseph DeLee of Chicago, in his now famous article, "The Prophylactic Forceps Operation," urged that use of forceps and episiotomy be made routine practice in normal delivery. The operation, DeLee argued, restored the mother to "better than new" and saved the child from brain damage and a life of crime (18). The acceptance of these procedures gave impetus to the growing hospitalization of birth. DeLee subsequently had different thoughts about his innovative operation but it was too late. In 1936 he wrote (17):

But another danger is developing; too much operative intervention. If the woman were at home . . . premature forceps or cesarean section would be harder to do, and the attendant would give her a long test of labor and often find that intervention was unnecessary. On the other hand, operation is too easy in the hospital, and the partially trained obstetric specialist trusts too much to a highly developed "surgical technic" or to his having many assistants . . . or to blood transfusions, counting on these to repair the damage of his trespasses of obstetric judgment and skill . . . Would anyone deny that there would be fewer cesareans, etc., if the woman stayed at home? . . . And can anyone prove that the greater number of cesareans that are done annually really have saved so many lives as to justify them?

During the 1920s and 1930s hospitalized births were promoted by obstetricians, public health officials, upper-class women, and insurance agencies alike (19). With a promise of painless and safe deliveries, both wealthy and middle-class women flocked to the hospital. It was the "lower" half of society that clung to the midwife and her services: the rural poor and the immigrant working class in the cities. But with the growth of hospital obstetrics there was a new need: "It is at present impossible to secure cases sufficient for the proper training in obstetrics, since 75% of a material otherwise available for clinical purposes is utilized in providing a livelihood for midwives" (20). The transfer of poor patients to the hospital and a concerted anti-midwife campaign resulted in a drop of midwife-attended births from approximately 40% in 1915 to less than 11% in 1935 (1).

By the 1950s many rural families who previously had had no alternative but to give birth at home were provided access to local hospitals newly constructed under the 1946 Hill Burton Act. To facilitate the architectural design of these new small hospitals, the United States Public Health Service issued a series of standard floor plans that institutionalized prevailing birth practices. Mothers were transferred from one place to another for labor and delivery; mothers and infants were separated at birth; and fathers were separated from the entire birthing process and relegated to a waiting room

outside the obstetrical suite (21). The construction of these small hospitals was an attempt to provide medical resources to communities that previously had no technological medical facilities. But as sophisticated medical technology increased, the larger urban hospital acted like a giant centripetal force, attracting physicians from all parts of the city and countryside. The growing medical concentrations known as “pill hills” depleted medical care from rural areas and poorer sections of the city as well.

As hospitals grew in size, efforts were made to rationalize processes and costs. During the 1950s and 1960s, operations research techniques used to expedite the manufacture of various forms of weaponry in World War II were now applied to developing more efficient obstetrical suites (22). Approached like any other industrial process, hospital maternity procedures were designed to keep the flow of patients moving—to avoid crowding and possible back-up. Priorities were formulated to facilitate the efficient processing of as many women as possible rather than to allow for an adjustable tempo for each individual birth. The factory approach was soon incorporated into textbooks on hospital design: “The conveyor belt concept has its use in analyzing our problems. It emphasizes the repeated transference of a mother (as in motor-car assembly) from place to place, and also that unequal time periods at any station can render the process uneconomical” (23). Hospital obstetrical suites became increasingly mechanized and dehumanizing.

The Reaction Against Hospital Birth Practices

Natural methods of labor and delivery were introduced to British hospitals in the 1930s by Dr. Grantly Dick-Read (24). During the 1950s, a French physician, Dr. Fernand Lamaze, began teaching methods for reducing pain in nonmedicated childbirth (25).

In the United States, persons too poor to afford a hospital birth, or living in areas where there were still no hospitals, continued to rely on midwives. Some midwifery services developed excellent records of safety in home delivery, even with clientele who were poor and often had high risk problems. Examples are the Maternity Center Association in New York, the Frontier Nursing Service in Kentucky, and the Catholic Maternity Institute of New Mexico (26).

Although these groups were providing in the 1950s successful models for the normal childbirth methods practiced today, widespread opposition to hospital birth procedures did not begin in the United States until the 1960s with the growth of the women’s movement. Couples who previously would have selected hospital delivery began to deliberately bypass the physician and other trained obstetrical personnel. Some fathers insisted on participating in all aspects of birth. An increasing number of women demanded to

return home immediately after delivery with or without official medical sanction. Some mothers spurned the simplest medical amenities during childbirth, occasionally at hazard to themselves and their newborn babies.

The hand of those who oppose traditional hospital delivery was strengthened by both the arrival and departure of the 1950s baby boom. In 1958, the metropolitan hospital clinics in the New York area were crowded with mothers seeking prenatal care (26). Delivery rooms were full, mothers were delivering on stretchers in the hallways, and there was a shortage of skilled personnel. The employment of Certified Nurse-Midwives was revived and was, in turn, instrumental in establishing alternative birth environments and family-oriented delivery systems. This transformation was aided by a decrease in the birth rate in the early 1960s when, suddenly faced with underutilized maternity suites, hospital administrators and staff introduced alternative birth practices and settings to entice patients in what had become a buyer's market.

These alternative practices attracted a small, rebellious, and largely middle-class clientele. By the 1970s, widespread opposition to hospital birth had gained sufficient strength to be recognized by itself as a movement. An increasing number of books and articles were published challenging hospital birth practices; a sampling of titles indicates growing anger and rejection: *Immaculate Deception*, by Suzanne Arms, *The Cultural Warping of Childbirth*, by Doris Haire, and the *Theft of Childbirth*, by Adrienne Rich (27-29).

The issues of particular concern to the childbirth movement include the inappropriate and possibly hazardous use of technology, separation of mother and infant, alienating hospital environments, high maternity bills, and lack of confidence in the fragmented and depersonalized maternity care system.

TECHNOLOGY Many questions have been raised as to the safety of modern chemical and surgical interventions in the birthing process. These include routine electronic fetal monitoring, chemical stimulation of labor, the routine use of anesthesia and forceps for delivery, routine episiotomy, use of pharmacological methods of pain relief, and overutilization of cesarean section. Some question whether these procedures have been subjected to controlled scientific investigation before their implementation on a widespread scale; the general improvement in mortality rates has sometimes been used to justify continued intervention without sufficient evidence of a causal relationship (30, 31).

The increasing use of medical techniques developed for high risk patients raises concern that these procedures might become routinely utilized for all women independent of their choice or full understanding of the risks and ramifications of the procedures. In a research report on costs and benefits

of electronic fetal monitoring (EFM), Banta & Thacker state that "the risk from EFM is substantial, especially but not wholly through the increased CSR (cesarean section rate) that its use apparently engenders" (32). In another study, involving 100,000 births, there were indications of "a small but significant negative effect on the newborn of both elective induction of labor and elective stimulation of labor" (33, 34). These practices are used in 20 to 30% of labors in the United States.

Some critics think that technological approaches to birth result more often in cesarean section. Over the past decade, cesarean sections in California have increased more than 300%, from 5.1% of all deliveries in 1965 to 15.4% of all deliveries in 1977 (35). The benefits of this increase have not been shown clearly. Various published findings indicate increased incidence of operative and postoperative complications (36). One California study showed "maternal mortality rates associated with cesarean section were twice those associated with noncesarean births for the years 1973, 1974, and 1975. . . . The potential problems that cesarean section may create for mother and infant are higher rates of iatrogenic prematurity and respiratory distress and of maternal morbidity and mortality" (37). Defenders of the surgery reply that these risks are greater when cesareans are done in small hospitals and by nonspecialists—arguments supporting larger hospitals and increased technology—but the costs and benefits of cesareans seem no clearer in 1980 than when questioned by Dr. DeLee in 1936.

SEPARATION OF MOTHER AND INFANT Much has been written about the importance of bonding between parents and infant during the first few hours of the infant's life. Klaus & Kennell suggest that this is a sensitive period of time when it is important for mother and father to have close contact with the newborn who must "signal" back, thus commencing interaction (38). Their studies and others indicate that separation of mother and infant at birth impedes bonding and causes harm to future family relationships. Early separation has also been linked to child battering and failure to thrive without organic cause (39).

HOSPITAL ENVIRONMENT In a 1977 report to the California Legislature, the Committee to Study Alternative Birthing reported substantial consumer dissatisfaction with hospital birth practices; among their objections were insensitivity of personnel to the emotional needs of new families, lack of support for mothers who insist on rooming-in, seemingly impersonal care, and perceived complete loss of control over what is being done to oneself and one's child (40). Minority groups and poor families have protested mainstream obstetrical services by not coming to facilities; many women arrive at the hospital for the first time in labor. Underuse of avail-

able facilities is partially due to their location, distant from user's homes, and partially, it appears, to a mistrust of the hospital environment.

Some hospitals have tried to allay distrust by instituting tours of obstetrical suites prior to delivery, but these tours sometimes appear to increase anxiety rather than to relieve it (27). The large size of the institutions, the hermetically sealed environments, the artificial ventilation, the synthetic materials, the standardization, the lack of familial support systems, and the large amounts of medical equipment have all been identified as sources of fear and stress, which obviously affect the process of labor and delivery (41).

COST The high cost of birth, which increased over three-fold in the United States between 1950 and 1980, is often cited by those who would reduce reliance on expensive technology. The Committee on Alternative Birthing found that the "repeatedly expressed dissatisfaction of (California) consumers with the high cost of maternity care has resulted in negative feelings attached to childbirth and, in some parents, in feeling obligated to seek alternatives based solely on price" (40). If there were no limits to the birth budget then any expenditure that could aid in facilitating the birth of a healthy baby would not be questioned; however, there is no doubt that this is a period of limited resources. The hospital system takes over 40% of the total medical budget, thereby reducing the possibility of alternatives.

Once a commitment to build is translated into bricks and mortar, the capital investment and the long-term need to justify it affects the users. Long after the original decision makers are gone, buildings continue to enhance or impede the activities that take place there. Many women still suffer from design decisions made by architects and hospital personnel in the 1920s that resulted in impersonal and uniform birth routines. In turn, the investment in the building of large scale regional medical centers will affect the birthing patterns of the next generations of women and their families.

DEPERSONALIZED AND FRAGMENTED MATERNITY CARE Many women coming from other countries where midwives are the traditional helpers during birth feel ill at ease with male attendants. This is often compounded by the inability to communicate in the same language and by the fact that physicians and patients come from different social classes with different social mores.

Some women have also criticized the fragmentation of care associated with traditional hospital delivery and prenatal care. From pregnancy to birth, a woman might see half a dozen or more practitioners in as many different settings; the result can be a disorienting, stressful experience (42).

Several examples show the positive results of watchful and concerned care provided during pregnancy. In Madera county in the early 1960s nurse-midwives provided this kind of care and the perinatal mortality was reduced in half (12–15). In Su Clinica Center located in the southern tip of Texas the migrant family health clinic recruited two certified nurse-midwives to work at the child bearing center. In a five-year period from 1972 to 1977, the premature infant rate for Su Clinica Center was 3.5% whereas it was 7.6% for the rest of Texas and 7.4% for the United States as a whole (26).

Home Birth

The critiques of hospital birth practices led inevitably to a resurgence in home births. Until quite recently, the percentage of home births in the United States had been declining from over 95% in 1920 to 73% in 1935, 5.6% in 1955, and less than 4% in 1961 (1). This decline brought with it a steady decline in the number of professionals trained to assist home childbirth and the disappearance of the traditions of home birth practice that had been passed down by women from generation to generation.

Recently, in the United States, particularly on the West Coast, there has been a resurgence of interest in home birthing and home birthing services. Estimates of out-of-hospital births range from less than 1% in some states to as high as 15% in some northern California counties. The current guide to alternative birthing environments lists home birth programs throughout the country that are operated by a variety of interdisciplinary groups including nurse midwives, day midwives, physicians, childbirth instructors, nurses, and nutritionists (43).

Proponents of home birth state that the home allows the normal mother and her family to take responsibility for self care and to have maximum control over the quality of the environment, the people present, and the range of medical intervention permitted. Families choosing home birth frequently mention distrust and disillusionment with hospitals, saying they could not relax and have a normal birth without the guarantee that friends and family could be present, unfamiliar attendants excluded, and unnecessary surgical intervention prevented (44–46).

On the issue of safety, statistics suggest that home births do not correlate with high infant mortality rates (47). The Netherlands is cited as having one of the lowest mortality rates, with 45% home deliveries. Although the trend in Holland is toward more hospital births, Dr. G. J. Kloosterman, Professor of Obstetrics and Gynecology at the University of Amsterdam, argues that the degree of hospitalization is not the significant factor in improving the results of obstetrics, but rather the care given prior to delivery and after birth. He cites the fact that Netherlands cities with almost total hospitaliza-

tion have results inferior to other cities with less than 50% hospitalization (48, 49).

Out-of-Hospital Birthing Centers

Over 50 independent birthing centers are now operating in different parts of the United States. Staff, facilities, and populations served vary greatly from one to the next (43). One of the first centers was started in 1975 by the Maternity Center Association (MCA), a national voluntary health organization based in New York. The Childbirth Center was organized to offer a "safe alternative to those parents who, for a variety of reasons, opt out of the system and choose homebirth—do-it-yourself maternity care" (50).

Between 1931 and 1959, MCA had conducted a very successful home delivery service in the upper Manhattan community of New York City, comprised primarily of a poor, high risk population. When asked why they did not continue home delivery, staff gave two reasons: high cost and unsafe streets, particularly at late hours. According to Ruth Lubic, Certified Nurse Midwife (CNM), General Director of MCA, the cost of providing sufficient home service is higher than the cost of providing services in a centralized place; furthermore, with the overall shortage of trained personnel experienced in low risk childbearing, nurse-midwife time is more effectively spent in a familiar and well-equipped environment (50).

MCA's objectives reflect those of most out-of-hospital birth centers, namely: (a) to provide highly personalized care at lower than hospital cost with a minimum of technical intervention; (b) to enable parents to retain control of their childbearing experiences as responsible and informed members of the team; (c) to offer a friendly, homelike setting with adequate obstetrical supplies at hand, located only minutes from a hospital should one be required; and (d) to provide excellent prenatal and postnatal care and education (51). Behind these principles is the conviction that childbirth is an important experience in family life and a healthy, rather than a sick, function of the body. The MCA's center occupies the garden level basement of an East Side townhouse and includes two birth rooms, family room, kitchen, and bathrooms. Approximately 350 families are served annually.

Another center, serving rural Chicano families, was started in Albuquerque, New Mexico, in 1975 (52). The Southwest Maternity Center is an independent nurse-midwifery practice with back-up obstetricians and pediatricians serving 150 families annually. The adobe-style building it occupies is over sixty years old, built around an inner patio with garden and sitting area. The new center, started by parents and midwives, filled a gap left by a previous center that was operated by the Catholic Maternity Institute during the 1960s but that closed in 1970 because of insufficient consumer and government support. Like the MCA, the Catholic Maternity

Institute has a long previous history, from 1944 to 1970, of providing safe nurse-midwifery services for home births.

Birth Center, Lucinia Inc., in Cottage Grove, Oregon, was founded in 1976 by a team that included a family physician, a nurse midwife, and a dietician. Irene Nielsen, the nurse midwife, described the philosophy of the birth center as a "triangle, placing the pregnant couple at the apex or top in a leadership role with rights and responsibilities for their own health care. Across the base of that triangle are the professionals with areas of interest and expertise" (53). Facilities are modest: a clinic, occupying a remodeled store, connected to a birth home, occupying a remodeled cottage. The two buildings represent two distinct domains: the medical domain, where professionals are in charge of clinics and classes, and the family domain, where families are in charge of the childbirth unless an emergency requires medical intervention. Approximately 150 families are served yearly.

Despite the increasing numbers of childbearing centers, licenses are difficult to obtain. Depending on state regulations, different centers are operated under different laws: some as clinics, some as maternity homes, some as physician offices. Most states have no codes that apply specifically to childbearing centers. In New Mexico, for instance, there are three licensure categories to choose from: maternity homes of five beds or less, requiring only safety precautions; maternity shelters of 20 beds, requiring certain structural details; and maternity hospitals of fifty beds, which are expected to meet the requirements of the Joint Commission on the Accreditation of Hospitals (52). People experienced with operating these centers caution against attempts to conform to hospital codes, which have many expensive regulations, for both facilities and staffing, that do not have direct application to alternative birthing environments.

Proponents of out-of-hospital centers cite good statistics on mortality and morbidity, lower costs, and ready access to hospitals. Those favoring hospital environments cite the unnecessary risk of reduced accessibility to emergency care (54).

In-Hospital Birthing Centers

The development of in-hospital birthing centers known as alternative birth centers or ABC units came into being in a period of a declining birth rate and an increasing number of home deliveries. They developed as a means of winning women back to the hospital. One hospital reported: "Experience . . . has demonstrated the significant value of the ABC unit as a loss leader, both in terms of favorable publicity . . . and the potential for generation of spin-off revenue in the Intensive Care Nursery and other departments" (55).

The ABC unit represents an attempt to duplicate the amenities of a home within the technological environment of the hospital. Typically, a woman

labors and delivers in a spacious home-like room with the support of a small number of trained, often familiar attendants, and as many family members and friends as she wishes and as the room permits. As is the case in out-of-hospital centers, use of ABCs is generally limited to low-risk mothers who have completed required training. Staff and patients are dedicated to unmedicated, vaginal birth, but any complications are generally seen as indicators for transfer to the labor and delivery suite. Postpartum care is generally unobtrusive, with the family encouraged to spend some quiet, private time with the infant to initiate breast-feeding and to encourage early bonding. Again, the settings and populations served vary widely.

The first hospital ABC was developed in 1969 at Manchester Memorial Hospital in Farmington, Connecticut (56). The hospital room included a labor-delivery bed imported from France. Mother, father, and newborn were allowed to remain together in the same room during recovery and could be discharged as early as 12 hours after delivery.

The Alternative Birth Center at Booth Maternity Center (the Salvation Army Hospital) in Philadelphia opened in 1971 and has attracted many single women as well as married couples. The freestanding maternity hospital has offices on the first floor and delivery facilities on the second, including an early labor lounge, a 24-hour kitchenette, labor and birth areas, 16 postpartum beds, and a nursery (57).

Another ABC was opened in 1976 at Mount Zion Hospital in San Francisco under the direction of Dr. Roberta Ballard. A neonatologist experienced in providing high risk care, Dr. Ballard recognized the need to have a supportive family environment when she experienced her own first pregnancy (58). The new center was predicated on the assumption that what was good for high risk mother and infant was not necessarily good for the woman experiencing a normal or low risk pregnancy. An advisory board, which included professional staff, childbirth educators, and consumers, recommended that siblings be allowed to attend the birth. If all goes well, families may leave the hospital six hours after birth.

Architecturally, the development of most ABCs has been neither difficult nor expensive. The ABC at Mt. Zion may be considered a prototype for facilities around the country. The physical setting resembles a comfortable hotel with a large bathroom, comfortable furniture, and soft carpeting. Emergency equipment is stored out of sight; stereos and soundproof walls allow music without disturbing other hospital occupants. Both lighting and temperature can be adjusted rapidly to accommodate personal preference (59).

The Alternative Birth Center that opened at San Francisco General Hospital in 1975 resulted from the joint effort of a nurse-midwifery service that needed a place to practice and an obstetrical staff with fewer than 30

deliveries a month that needed to attract more mothers. The service now handles over 120 deliveries a month.

Judith Goldschmidt, CNM, coordinator of the San Francisco General Hospital's ABC unit, reports that there has been a liberalization of rules all over the hospital (61):

We have found that many things we called scientific, that we justified on the basis of being reasonable, rational procedures, were really very much rituals—an expression of belief systems that maybe did not best support the best efforts of women having babies. We have found that we no longer need automatically to use IVs, that people can drink and eat during labor, that we haven't had an increase in infection or an increase in problems with aspiration. We have found that women's labors go better if they can move around, if they're allowed and encouraged to do that. And (mothers) having their babies with them right away after birth has become the goal of the whole labor and delivery area.

About 50% of the families using the ABC at San Francisco General choose the service because they want a female attendant or because they come from countries like Mexico, El Salvador, and the Philippines where midwives are the usual birth attendants. Goldschmidt is pleased to be able to provide choices at a county hospital to the patients whom she feels are usually the last to be offered genuine choices or encouraged to assume responsibility for their own care (61).

Family centered maternity and newborn care is now supported by the major health professional organizations.¹ In 1978, a joint committee of these associations endorsed the "delivery of safe quality health care while recognizing . . . and adapting to both the physical and psychological needs of the client-patient, the family, the newly born" (62). The American Hospital Association has since added its support.

The committee recommended that hospitals that develop ABCs include the following (62):

1. The option of a homelike birthing room.
2. Flexible rooming-in with maximum mother-child contact during the first 24 hours.
3. Breast-feeding and handling of the baby immediately after delivery.
4. Father or other support person allowed to be present throughout labor, delivery, and recovery periods.
5. Siblings allowed to visit in a special family room.
6. Optional early release from the hospital with careful follow-up after discharge.

¹The American Academy of Pediatrics (AAP); The American College of Nurse-Midwives (ACNM); The American Nurses Association (ANA); The American College of Obstetricians and Gynecologists (ACOG); The Nurses Association of the American College of Obstetricians and Gynecologists (NAACOG).

Dr. Robert Freeman, a professor of obstetrics and gynecology who specializes in high risk pregnancies, commented that "Family centered, home-style birthing . . . has really let a lot of us look at ourselves. It has been like turning on a tape recorder and listening to the things we say in front of patients." He points to changes that have occurred in his tertiary hospital, including encouragement and help for breast-feeding mothers, the right to demand a vaginal delivery, fathers permitted not only in labor and delivery rooms but, more recently, in cesarean delivery rooms. Freeman credits consumers with initiating these changes (63).

Critics of hospital ABCs claim that the very proximity to hospital services leads birth attendants to intervene prematurely and to transfer mothers unnecessarily to the labor and delivery suite for minor indications. Transfer rates as high as 25% have been recorded for well-screened, low-risk mothers (58). Some suggest that this is the result of midwives being replaced by physicians, who are neither trained nor experienced in low-intervention birth. In a comparison of cases handled by physicians and by midwives at Roosevelt Hospital in New York, mothers attended by midwives faced significantly less surgery, fewer uses of forceps, and fewer cesareans, episiotomies, and complications (64). On the other hand, proponents of ABCs suggest that screening for hospital ABCs be liberalized, since transfer to labor and delivery rooms is relatively simple. Many higher risk mothers would like to attempt normal birth with maximum emergency back-up but are not permitted to do so (65).

The Centralization of Obstetrical and Neonatal Care

Despite this concession to normal childbirth, the goal of professional medical organizations is toward the closing of small hospitals and the location of birth in larger, more centralized units that have the immediate capability of handling high risk pregnancies and, to varying degrees, high risk infant care.

The specific guidelines for consolidation of services into larger and more technological centers were outlined in 1976 in a document sponsored by the March of Dimes, "Toward Improving the Outcome of Pregnancy—Recommendations for the Regional Development of Maternal and Perinatal Services" (66). This monograph represented the collective thinking of representatives of the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Pediatrics, and the American Academy of Family Practice.

The guidelines, which were generally supported by the United States Department of Health, Education and Welfare (HEW), outline a "regional system" comprised of three types of hospitals. Level III, with the most highly developed technology and the most specialized staff, would be the

tertiary center for obstetrical and neonatal care. HEW estimated that to be economically viable, a tertiary center would have to provide delivery services for 2000 to 3000 women annually and handle 300 to 400 neo-natal transfers. Level II hospitals would be expected to handle neo-natal illnesses as well as a full range of delivery services; Level I hospitals would be encouraged to consolidate or close if they handled fewer than 500 deliveries in a year (66).

Critics of the plan feel that it is heavily oriented toward treatment of disease, high risk care, and crisis intervention (67–69). They state that the guidelines emphasize development of Level II and III hospitals, that closure of small hospitals will reduce access to preventive, primary obstetrical care, and that concentration on technological childbirth services will inevitably increase their use. Opponents also point to the lack of provision for out-of-hospital birth centers or home birth, and the lack of consideration for the well-documented preference of local jurisdictions to maintain small hospitals (70, 71).

Studies are underway to evaluate the costs and benefits involved in neonatal intensive care (72). Many worry about the ethical issues of who decides whether, indeed, a premature or high risk infant should be saved or allowed to die (73, 74). Dr. Neil Kellman, a pediatrician and architectural designer, suggests potential harm to premature infants from the intensive care unit itself. He cites as potential hazards artificial lighting, intense radiation, the trauma of the procedures, and possible noise levels in excess of industrial maximums in incubators with life support systems (75). These criticisms suggest the likelihood that, despite some medical successes, the larger obstetrical and neo-natal units will exacerbate the same kind of alienation that produced the alternative birth environments in the first place.

Summary

The last decade has witnessed, on the one hand, an unprecedented advance in technology to care for high-risk mothers and infants and, on the other hand, widespread understanding of normal childbirth, family-infant attachment, and the success of non-medical, less technological environments for pregnancies.

Many professionals still see birth as a medical—and potentially pathological—process. For them, success is measured in terms of how technical intervention affects the perinatal (first 28 days of life) mortality rate. Extra-medical factors in survival and nontechnological approaches to care are not considered. This attitude is being reinforced by government support of a developing perinatal intensive care industry.

There are an increasing number of women who do not want to be passive recipients of maternity care under the control of an obstetrician, but who want to reclaim birth as an important rite of passage under their control. Fear and distrust of overmedication and the unwarranted use of technology have given rise to an increase in home births and the development of a variety of alternative birth environments. This transition has been a positive one, enabling thousands of women and an increasing number of health care professionals to regain a traditional understanding of the normal process of childbirth.

In America, there is a tendency to look at pieces of problems rather than to look at them in their larger social context. We think of the birth environment as a place, and birth as a moment. Rather, the birth environment is a totality comprised of the people, the place, the attitudes and traditions and conditions of life affecting women prior to, during, and after the birth itself. Who makes the decisions may be the critical question of the 1980s. There is sufficient evidence to show that for a number of women attitude and confidence in the entire birthing system may be the most significant factor affecting the outcome of pregnancy (76, 77).

PART II: HOSPICES

Decisions on Death

Dying, like birthing, was traditionally a family event that took place in the home, except for the very poor, who died in hospitals and poor houses. Now over 70% of deaths take place in hospitals or nursing homes.

With the increase in medical technology, e.g. intravenous feeding, heart-lung machines, it is now possible to keep people alive for hours, days, weeks, months, even years. This technical ability, combined with both a medical ethos of the importance of saving every life at whatever cost and a threat of malpractice suits if one does not use heroic efforts to maintain life, poses tremendous social and ethical problems. Increasing numbers of people are signing "living wills," which state that they do not want to be kept alive by technological means after there is no hope of recovery in the terminal period. But neither do they want to be "written off" too soon. At the center of the dilemma is the issue of who decides, for whom, and under what circumstances should it be possible for the terminally ill patient to refuse medical treatment and to turn off the life-saving equipment or to enter a program of palliative care.

A History of Dying

Prior to the twentieth century famine and pestilence decimated whole sections of the population and took their toll from young and old alike. Death

was everywhere and occurred without warning. With better food and sanitation and a decrease in infectious disease, the United States, as well as other industrialized countries, witnessed a significant shift in mortality figures during the twentieth century. "During most of man's existence, it is probable that a considerable number of children died or were killed within a few years of birth; in technologically advanced countries today, more than 95% survive to adult life" (78). Whereas life expectancy at birth has improved by over two and a half times, life expectancy at 70 has changed very little (it is now approximately 12 to 13 years). The difference is that in earlier times relatively few people managed to reach the age of 70, whereas under present conditions, nearly two-thirds of the population reach that age. Death is no longer an omnipresent household event but occurs mostly in old age, often after the extended family has already broken up and the members are already living in different geographical areas.

As hospitals improved and the image changed from "houses of death" to places of possible cure, death like birth moved more and more into the hospital setting. As each new technological breakthrough developed, the hope grew that death might even be staved off indefinitely (79).

From the 1930s through the 1960s families sent their dying members to the hospital, partly because they believed they might be saved and partly because they could not be accommodated in small apartments, attended by working wives or mothers, or by families living at great distances from each other. With the hospitalization of the dying, most families became less acquainted with death and less able to cope with it when it occurred (80, 81). By the late 1960s public payment mechanisms—Medicare and Medicaid as well as Blue Cross and other insurance—made it possible for providers to pass on the high costs of technology associated with hospital death.

With the increase in the use of technology, hospital death became more and more dehumanized. Descriptive studies documented the loneliness of hospital death, the desire of nurses and attendants to avoid the death scene, the wrapping of the body, and the attempts by staff to send families home to avoid a disturbance when a patient died (82).

In actuality nurses strive to separate relatives from those patients whose deaths are regarded as imminent. . . . They urge family members to go home and await further news there or, at best, insist that they wait outside in the corridors and not in the patient's room. At least part of their concern in doing so is to handle the forthcoming death within the context of other ward responsibilities. It is common for a patient to die unattended and be discovered as dead only considerably later, when, a nurse, aide, or doctor happens into his room.

It became impossible to ignore the horror of death in the hospital and the inescapable human involvement with death was reasserted (83, 84).

Dr. Elisabeth Kubler-Ross, a Swiss-born psychiatrist who lives and

works in Chicago, is one of the most influential people contributing to shifting attitudes on death and dying in the United States. Her book, *On Death and Dying*, published in 1969, resulted from numerous interviews with dying patients and her efforts to get nurses and physicians to deal with patients about death in a humane and truthful manner (85). She has been criticized for arranging the dying patient's feelings into overly neat categories: from denial to bargaining to acceptance. Regardless of this criticism, she has opened up and continued a discussion on how we die.

In England, about the same time, Geoffrey Gorer wrote of Western societies' denial of mourning, to which he attributed an increased callousness toward risk of death and an irrational preoccupation with fear of death. "A society which denies mourning and gives no ritual support to mourners is thereby producing maladaptive and neurotic responses in a number of its citizens" (86). Gorer advocated the revival of secular mourning rituals for the bereaved, their kin, friends, and neighbors. His writings influenced the attention to bereavement developed as part of the hospice program.

An increasing number of people both within and outside the medical professional have begun to question whether the hospital offers the most appropriate services to the terminally ill (87, 88):

A general hospital is often unsuitable for the dying patient. It is busy day and night, when he needs peace. It is geared to cure, and so the staff may see a dying patient as a failure for whom they can do nothing. Worse still they may try to prevent him from dying by applying all manner of inappropriate treatments or they do not know how to control pain.

In a typical hospital . . . care of the terminally ill is clearly a secondary concern, and in fact its goals, methods, and values are at some deep level hostile to the very enterprise. The function of a hospital, after all, is to promote healing, and dying patients by definition are not pointed to recovery but inescapably represent the system's failure. As such, they may well be perceived as a rebuke to its commitment to healing, as a source of guilt or shame on the part of the staff, or simply as an interference with settled routine.

The issue is presented perhaps most succinctly by Dr. Edward Hurley, a professor of surgery (89):

The process of dying is often enveloped in conflict. The conflict rests not in the opposition to the ultimate by the patient, but in the intense involvement by others introducing a process of dying. It is this process that often isolates the patient, deprives him of his usual environment, sense of normalcy and some dignity.

This acknowledgment of terminal illness and the necessity for extended and supportive care are fundamental to the development of the modern hospice. The word *hospice* derives from the Latin *Hospitium* and was originally the name given to the resting places where religious communities of the Middle Ages welcomed pilgrims until they were able to continue their

journey. The first hospice for the dying was opened in the middle of the nineteenth century in Dublin by an order of nuns, the Irish Sisters of Charity. In the early part of the twentieth century, the Sisters of Charity opened a similar house, St. Joseph's Hospice, in London. Both facilities provided, more than a physical setting, a humane approach to care of the terminally ill and their families (87). A decade ago, such programs were hardly known outside the United Kingdom. Today, hospices are established throughout northern Europe and the United States. In the United States today it is estimated that there are over 200 hospice groups and over 60 functioning hospices in 33 states (90, 91).

Defining the Hospice

TERMINAL ILLNESS The hospice program as currently conceived is applicable to only a small percentage of the population: those with a terminal illness, usually cancer, whose time of death can be predicted to occur within a year's time and whose remaining life can be made more comfortable outside the traditional hospital setting (92). Hospice care, then, is predicated on the ability and willingness to acknowledge certain death, a notion many Americans could not have accepted a decade ago. The other major elements of hospice programs are control of pain, care by families and volunteers, and support for bereavement (90–96).

CONTROL OF PAIN Much of the work of hospice workers is in reducing physical distress by treating vomiting, nausea, and incontinence and by making patients comfortable. Central to this work is the ability to control pain. Those who have seen dying patients in severe pain say that it is impossible for patients to relate to other people in that condition. Modern methods of pain relief are aimed at maintaining patients in an alert rather than a sedated condition, and in a condition in which they are able to relate to families and friends. In Britain, patients are often given Brompton's mixture, a concoction of heroin, cocaine, alcohol, and fruit syrup. In the United States, morphine is typically substituted for the heroin.

The availability and use (often self-administered) of continuous doses of analgesics allows people to relax from the fear of unendurable pain. It is not a drug "high" but rather the restored sense of security that is the critical achievement of predictable pain relief (97–99).

CARE BY FAMILIES AND VOLUNTEERS Hospice programs rely heavily on the work of family members and volunteers, particularly in the home and community of the dying patient. The ratio of volunteer to paid staff has been as high as 134:1 (91). Most hospice workers agree that the presence and

continued interaction of loved ones provides the best mental and emotional support to the dying person. Families and friends are encouraged to learn how to care for the needs of the patient; often they are assisted by a visiting nurses service and by having access to a 24-hour call line with which they can ask for advice or help day or night. The emphasis on families and volunteers is based on the belief that personal involvement in caring (100)

... could not be taught theoretically in college. The more you study instead of do, the less can wisdom grow. Ten thousand role-playing sessions talking about death could only furnish one with lots of habits and stock answers, all of which would only get in the way when a real patient asks if he is going to get better or not. . . . You will gather from this that I am very suspicious of the professional "counselor". . . . Communication is a basic human duty. We should all be learning it, not leaving it to specialists. . . . Conversing and listening (a better way of describing "counseling," with less mystique) are part of medicine and nursing. If they are omitted, all that is left is technicians.

The remarkable aspect of the hospice programs is their ability to encourage and restore a sense of community by the very activity of caring for one another. Dr. Lamers, director of the Marin hospice, tells the following story (101):

One day a lady called and said, "I need some help. My doctor has just told me that I am dying, that I have only a month or so to live. I have no family, no friends. I'm eligible for Medicare, and I know that if I'm sent off to a nursing home, as the doctor suggested, that my dog who is sick will be taken away, and I couldn't stand that. Will you try and help?" We didn't know what to do because we don't take over and provide 24-hour care. Several of our nurses then went out and began to ring doorbells in the neighborhood. And within half an hour or so, they had a list of people who were willing to volunteer part-time, to be trained by our staff to care for the lady. They even learned to give insulin shots to her dog. This lady received beautiful care and died comfortably in her own home, and one of the neighbors asked to take the dog.

This type of community support for the brief period before death may be a worthwhile model for the caring required during one's total life span.

BEREAVEMENT Many hospices include what they have labeled "bereavement follow-up" as part of the services offered. It is unfortunate that the terminology connotes a professional tone to such a human response as hospice caring. Nevertheless, staff do assist families after a member dies, with anything from a supportive phone call to advice on how to resolve complicated social and financial relationships following death.

The service is offered partly in reaction to the impersonality frequently encountered in hospital intensive care units, and partly in the belief that openly expressed grief is necessary for coming to terms with loss and may help to mitigate some of the common negative responses to death, including alcoholism, depression, illness, and suicide (102).

British Prototype

The modern founder of the hospice movement is Dr. Cecily Saunders. Saunders is an Oxford graduate educated in philosophy, politics, and economics and became a nurse in World War II. After the war she took degrees in both medicine and medical social work. In the late 1960s, Dr. Cecily Saunders, then medical director of St. Joseph's Hospice in London, received money from the National Health Service to build St. Christopher's, now the model for hospices throughout the world. The 54-bed facility is made up of 4-bed wards, a few private rooms, a larger room for group activities, and family rooms for visitors. Patients are encouraged to bring some of their own belongings and to personalize their space. Color, natural materials, flowers, and paintings are used to create a feeling of warmth; ordinary, nonhospital beds are made more comfortable with large down pillows (87, 92, 96).

Because patients are drawn within a six-mile radius, there is active family involvement and support, with 10 to 15% of the patients returning home to their families for periods of time before their death (103). Visiting hours are 8 A.M. to 8 P.M., and children of all ages are encouraged to come and go. A play school for younger children of the staff is set behind the main building, adjacent to a garden with footpaths, reflecting pool, and flower beds. The success of this program draws several hundred patients and several thousand visitors and students annually. Although largely influenced by the hospice programs in England, the hospice programs in the United States have developed their own variety of home care services and out-of-home centers.

FREESTANDING HOSPICES Dr. Saunders of St. Christopher's has described the type of place that she sees as conducive to better care (92):

There should be space for families, windows for patients to look from, and opportunities for them to move around; room for staff to work easily and to relax; and transition spaces for the anxious to take time off or to brace themselves for a meeting. Above all, a feeling of openness to the world outside and good public transport are chief among the needs of a unit for terminal long-term care.

One of earliest hospice programs in the United States, and the one most modeled after St. Christopher's, is the Hospice for the Greater New Haven Region (Hospice, Inc.), located in the town of Branford, Connecticut. In operation since 1974, Hospice, Inc. has functioned as a home care program under the direction of Dr. Sylvia Lack, who was trained at St. Christopher's (104). Just this year, the hospice staff opened their own facility with 22 beds, half of the beds originally planned. It is one of only four freestanding hospices currently operating in the United States (91).

The architect of Hospice, Inc., Lo-Yi Chan, spent time at St. Christopher's in an effort to better understand the specific design requirements of this kind of institution. His goal was to create a place of beauty: "Even for the dying, beauty is healing" (105). Similar to St. Christopher's, patients at Hospice, Inc. are grouped in four-bed rooms for a community atmosphere and to avoid double rooms where the loss of one close friend may be more traumatic to the survivor. Some families have objected to the lack of privacy at the time of death, but staff at St. Christopher's have chosen not to remove patients from wards to die, believing strongly that if others dying see death occur in a comfortable and painless manner, they will fear it less (92).

The bedrooms at Hospice, Inc. look onto outdoor terraces. Corridors that run along both sides of the bedrooms, while appearing to limit privacy, encourage sharing and facilitate movement in all directions. Sister McNulty, retired head of the outpatient clinic at St. Christopher's, expressed it well: "Patients are trapped in their dying bodies; they must not also be trapped in their rooms" (105). A variety of transition spaces, such as anterooms and hallways, allow families to have a moment to themselves to prepare if necessary for visiting or for the trauma of leaving (106).

The freestanding hospice is subject to many of the same criticisms as those leveled at the out-of-hospital birthing center, by both the hospital and the home care movement. Although the hospice enables patients to avoid the negative status afforded the dying patient in most acute care institutions, a separate facility for the dying has its own negative connotations. The fact that it is an independent facility may make it more difficult to involve families in caring for dying patients if the patients are located outside of their private home environments (107).

Hospital-Affiliated Hospices

Several different hospice programs have been incorporated in hospitals. These include (a) separate inpatient nursing units, sometimes called palliative care units, (b) specialized treatment programs for dying patients, who are cared for along with other patients in existing nursing units, and (c) affiliated but separate facilities, often located on hospital grounds but in independent buildings (108, 109).

The first inpatient hospice service opened in January, 1975, at Royal Victoria Hospital in Montreal, Canada. The goals of the program have been described by the founder, Dr. Balfour Mount (108):

Family members are encouraged to participate in patient care. When necessary to meet the individual needs of the patient-family unit, hospital regulations are relaxed to allow relatives to stay overnight and children—and even pets—to visit. Care is individualized. Blood pressure, pulse and temperature are not taken routinely. The only investigations and treatments performed are those directly related to the alleviation of problematic symptoms.

In California, Kaiser-Permanente has operated a six-bed hospice unit in their Hayward Hospital since 1977. The staff is small: a nurse coordinator, a psychiatric consultant, one registered nurse, several licensed vocational nurses, and dedicated volunteers. Their goal is to offer patients emotional support and physical comfort, to avoid unnecessary medical intervention, and to encourage conversations (100).

Hospice programs do not have to be large or centralized. Since 1975, a group called the Symptom Control Team has been working at St. Luke's Hospital in New York to help dying patients, who are located throughout the hospital rather than in a single unit or wing (90). In another approach, the Department of Oncology at Stanford University Medical Center employs a clinical social worker whose job is not only to provide emotional support to cancer patients and their families, but also to coordinate community health resources to support care at home whenever it is feasible (108).

A danger of the hospital-based hospice is that it will "sell" the concept of hospice to fill vacant beds without carrying out the full program and detract from the community supports developed in the home care programs.

HOME CARE PROGRAMS The majority of hospice programs in the United States function as home care services. Dr. Edward Lamers, one of the founders of the Marin Hospice in California, outlined the development of their program (101):

Our first thought . . . was that we needed a building. We had an "edifice" complex. Now we realize that hospice care is a concept, that it is a method of help provided in order to change existing institutions and modes of care. So we work with patients in their own homes. A few will be in hospitals or extended care facilities—skilled nursing facilities, nursing homes.

Even with their emphasis on home care, staff at the Marin Hospice now would like to have a small eight-bed facility, preferably an old house, in order to provide a noninstitutional environment for the few patients who can't be cared for at home.

A Connecticut survey of deaths from cancer between 1969 and 1971 showed that 67% of those patients had expressed a desire to die at home as opposed to the 20% who did die at home (95). For people who prefer to die at home, or at least to remain at home for as long as possible, hospice home care programs can offer the essential support. Typical of other programs, the Marin Hospice offers 24-hour, seven-day-a-week back-up service to advise families inexperienced in the needs and care of the dying to accommodate difficult situations as they arise. This approach enables patients to live in their own homes with their loved ones and pets and familiar possessions.

The idea of the hospice is to allow for a "natural" death. It permits those approaching death to continue to live alertly, to reject the machine-attended death offered by most intensive care hospital settings, and to experience a sense of well-being; as expressed by Dr. Saunders (110):

The care of the dying demands all that we can do to enable patients to live until they die. It includes the care of the family, the mind, and the spirit as well as care of the body. All these are so interwoven that it is hard to consider them separately. I believe, however, that the most important factor of all is an atmosphere of such welcome and confidence that a patient can end her talk with me by saying, "But it's so wonderful to begin to feel safe again."

Summary

Despite the growth of hospices in the United States, public policy continues to favor institutionalized dying. Hospital-based or affiliated programs have received some reimbursement from Medicare and commercial insurance, but many of the services of home care programs, which the majority of hospices are, are currently nonreimbursable. In fact, several principles advocated by those working in hospices—the self-administration of drugs, the ability to remain ambulatory—are antithetical to the requirements of dependency on which reimbursement is based. If we are really serious about the viability and importance of families and neighbors caring for each other, then we must provide for direct appropriations to make it easier for family or friends to care for the dying at home rather than subsidize only medically based institutions.

CONCLUSION

In industrial society we have allowed ourselves to rely on institutions and professional specialization to solve our most personal responsibilities toward birthing and dying. The solutions developed have been inadequate, dehumanizing, and alienating. Until the last decade most of us alive in America never saw a baby born or a person die. These events were hidden primarily in hospitals. Our lack of familiarity with the life processes eroded our competence and power to deal with them. Instead of approaching birth and death as natural events, we made them technical problems requiring technical solutions. Only recently has there been the growing recognition that "Birthing and dying differ from the usual patient situation. These phenomena are not diseases to be diagnosed and treated in the typical sense; rather, they are akin to what, in modern preventive medicine, we are inclined to call health maintenance for which there is required watchfulness, and care, support with intervention aimed not at cure but at support" (111).

The examples set particularly by the home hospice movement demonstrate how ordinary people within their own communities can successfully overcome difficulties and beautifully care for the dying in a human and cooperative manner. This reclaiming of birthing and dying may be the key to show us the way to reclaim control over many other aspects of our life from birth to death; not only for the short periods of time surrounding the rites of passage.

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