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# MIDWIFERY: STRATEGIES ON THE ROAD TO UNIVERSAL LEGALIZATION

*Laura D. Hermer*

The economically well-off American wife feels guilty about her comfortable, pampered life and wants to prove that she can accomplish things on her own. A few years back, manufacturers of a cake mix called on research consultants to find out why American women were not buying their product. The study showed that homemakers resented having the whole cake mixed for them. They could neither claim nor feel any pride of accomplishment in the perfect result. The findings of this study persuaded the cake mix makers to leave two key ingredients out of their product. The housewife would then have to add her own eggs and milk, and thus she could feel that the cake was really her creation. It worked, and the manufacturers learned an important lesson about feminine psychology: you can't make things too easy for a woman; she won't let you.

Madison Avenue would probably find in 'Natural Childbirth' a similar sort of 'do-it-yourself' reaction to the ready-made American world, another area in which women can reject the easier way in favor of a sense of accomplishment.<sup>1</sup>

## I. INTRODUCTION

Is childbirth as practiced in most hospitals in the United States today truly the "easier way" of giving birth, yielding the best results possible with the least amount of pain, risk and injury? Or are more natural, less intervention-driven methods of giving birth both medically and psychologically better for both mother and child, notwithstanding perhaps more pain, effort and uncertainty in the process? The time has passed when women were put into twilight sleep for the birth of their children and then, after awakening and resting for an appropriate length of time, were coiffed by a hairdresser

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<sup>1</sup> WALDO L. FIELDING & LOIS BENJAMIN, *THE CHILDBIRTH CHALLENGE: COMMONSENSE VERSUS "NATURAL" METHODS* 20-21 (1962).

for their family's first photographs with the new infant. Nevertheless, birth – ostensibly one of the most natural of human processes – still remains a technological and largely passive event for most women in the United States. It is common, if not routine, for almost all women delivering babies in this country to be subject to regular invasive monitoring, blood work, and withholding of food and most fluids during labor, and to have their labor induced or contractions augmented should delivery not take place sufficiently promptly.<sup>2</sup> The “epidemic” of cesarean sections and other obstetrical interventions in the U.S have been problematic for years. At the same time, study after study has shown that midwifery is just as safe, if not safer than, medical care in low-risk childbirth. Midwives are trained caregivers, usually but not always female, who provide care and support to pregnant women in the prenatal period, during labor and delivery, and postpartum.<sup>3</sup> Most births using midwives require fewer interventions than those attended by physicians, yet yield excellent results.<sup>4</sup> The results of these studies indicate that we should return to midwifery for normal births, rather than continuing to rely primarily on medicine.

This option, however, has been significantly curtailed by many state legislatures and courts, despite decades of attempts to make incursions on the traditional paradigm of hospital births attended by obstetricians. As a result, where midwifery is more readily available, it is generally available only from certified nurse-midwives (CNMs). CNMs are registered nurses who have undergone additional training in midwifery and who focus most of their work on caring for pregnant and delivering women. In order to survive and grow as a profession, CNMs often had to capitulate to the wishes of obstetricians and other childbirth practitioners, who are concerned about protecting their professional turf.<sup>5</sup> As such, they are frequently required to adhere to established medical protocols, procedures and oversight.<sup>6</sup> In recent

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<sup>2</sup> See, e.g., JUDITH PENCE ROOKS, *MIDWIFERY AND CHILDBIRTH IN AMERICA* 450-51 (1997). See generally, SUZANNE ARMS, *IMMACULATE DECEPTION: A NEW LOOK AT WOMEN AND CHILDBIRTH IN AMERICA* (1979) (discussing the mechanical process of birth as it seems in a hospital with a doctor).

<sup>3</sup> See, e.g., ROOKS, *supra* note 2, at 3-4 (describing the historical and etymological roots of midwifery as a predominantly female profession). Note that, because most (though not all) midwives are women, I will utilize feminine pronouns when referring to midwives throughout this paper.

<sup>4</sup> E.g., *id.* at 6-10 (explaining the various definitions and duties of a midwife in the United States and internationally).

<sup>5</sup> See ROOKS, *supra* note 2, at 82-84 (citing polls and speeches by medical organizations opposing the expansion and independence of the midwifery profession).

<sup>6</sup> See generally *id.* at 209-19 (evaluating the impact of CNMs' collaboration with physicians and the subsequent problems with those physicians, hospitals,

years, such care – at least during labor and delivery – has started to resemble that provided by many obstetricians.<sup>7</sup>

If one wishes to have a more natural and less intervention-oriented birth, one must instead often rely on direct-entry midwives (DEMs) rather than CNMs. DEMs are a diverse group of individuals.<sup>8</sup> Many, if not most, trained through apprenticeship, rather than or in addition to academic or nursing training.<sup>9</sup> Most are neither nurses nor physicians or other medical practitioners. DEMs may or may not have undergone and fulfilled formal licensing, credentialing or registration requirements. Some practice illegally, either in a state which does not recognize DEMs, or through choosing to practice without fulfilling a state's licensing, certification or registration requirements.<sup>10</sup> It is only in certain areas of the country that women have a realistic opportunity to give birth out of the hospital with a legally practicing DEM.<sup>11</sup>

Some DEMs have made constitutional challenges to state laws which curtail or prohibit their practice, arguing that they violate the midwives' right to practice their chosen profession or the mother's right to choose both the manner of her delivery and the practitioner who attends it.<sup>12</sup> Most court decisions in these cases have analyzed those laws using a rational basis standard, requiring the law to be rationally related to the advancement of a legitimate government interest without placing irrational burdens on individuals.<sup>13</sup> All have found the challenged statute or regulation to meet constitutional muster, usually following very little memorialized review.<sup>14</sup> In each case, the court found some ostensibly plausible reason for the legislature to have enacted the law in question. Yet, if the court seriously reviewed the decades of data showing midwifery to be as

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government regulators, and insurers as CNMs attempt to maintain independence).

<sup>7</sup> See *infra*, section III.

<sup>8</sup> MARY M. LAY, *THE RHETORIC OF MIDWIFERY: GENDER, KNOWLEDGE, AND POWER* 4 (2000). E.g., ROOKS, *supra* note 2, at 227 (explaining that although "DEM" originally referred to midwives that were not CNMs but had completed formal training or state licensing requirements, it is generally used to refer to all midwives who do not have the nursing training of CNMs).

<sup>9</sup> LAY, *supra* note 8, at 4. See ROOKS, *supra* note 2, at 229 (describing the DEM community's preference for experiential learning and its general distrust of universities).

<sup>10</sup> See ROOKS, *supra* note 2, at 292-93 (asserting that DEM's practice is illegal in many states and many DEMs will not attempt to become licensed locally or nationally).

<sup>11</sup> *Id.* at 292-94.

<sup>12</sup> See *infra*, note 202 and accompanying text.

<sup>13</sup> See *infra*, notes 206-09 and accompanying text.

<sup>14</sup> See *infra*, notes 210-13 and accompanying text.

safe as obstetrics in normal deliveries and to result in far fewer interventions and complications, it is unlikely that it could rationally have come to such a conclusion.

Why has this been the result? Largely, it is because obstetrics constitutes to be the dominant paradigm in this country with respect to birth. Over a century of education, proselytizing, and lobbying on the part of physicians and the groups which represent them has successfully led to the characterization of childbirth in the minds of the public as an inherently dangerous act requiring full medical guidance at an appropriate facility in order to obtain a safe outcome for all concerned.<sup>15</sup> Without such guidance, American physicians assert, women and their fetuses face mortal peril with no protection. And we overwhelmingly believe it.<sup>16</sup> This is unsurprising, when additionally given the history of childbirth up through recent decades. Considering the potential complications women and fetuses faced in parturition prior to the advent of modern aseptic technique, the development of antibiotics, and certain diagnostic capabilities, childbirth has always been potentially fraught with peril. Deaths from puerperal fever (infection following childbirth), malpresentations (where the fetus is positioned so that another part of its body than its head will be born first) and other problems, while not common, were once frequent enough to be legitimately feared by all laboring women.

What we fail to realize is that trained midwives are as safe and well-equipped as physicians to guard women and fetuses from danger in most births. As it turns out, it was not the presence or absence of physician birth attendants that led to a sharp drop in maternal mortality in the last century. Rather, the decline largely resulted from certain medical advances such as blood transfusions, antibiotic development and diagnosis and management of common complications.<sup>17</sup> Fetal and maternal morbidity and mortality rates are presently almost identical between physician and non-physician birth attendants.<sup>18</sup> Indeed, they have remained virtually identical for the past few decades.<sup>19</sup>

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<sup>15</sup> See ROOKS, *supra* note 2, at 22-26 (describing the opposition campaign to midwifery during 1910-1935 as physicians became a “newly unified medical profession”).

<sup>16</sup> Cf. Joyce A. Martin et al., *Births: Final Data for 2000*, 50 NAT'L VITAL STAT. REP., Feb. 2002, at 14, 71 (finding that nearly 100 percent of all births in the United States in 2000 took place in a hospital).

<sup>17</sup> E.g., ROOKS, *supra* note 2, at 30-31 (citing retrospective studies of maternal mortality between 1800 and 1950 and emphasizing the importance of penicillin).

<sup>18</sup> See *infra*, section III.

<sup>19</sup> *Id.*

Yet despite this, Americans still persist in believing only obstetrical management and delivery can preserve women and their fetuses from injury or death in childbirth.<sup>20</sup> Legislatures are far more likely to accept the testimony of physicians and their supporters in favor of imposing restrictions on the ability of other types of birth practitioners to attend to the pregnancies, labors and deliveries of women.<sup>21</sup> And many courts readily accept medical opinion testimony to the exclusion of contrary evidence when considering whether to uphold legislation restricting the licensure or scope of practice of those who wish to practice midwifery.

This paper considers why the numerous arguments in favor of midwifery and against obstetrical management of most pregnancies have generally been unsuccessful, and why the medical paradigm has – at least to date – generally won the day in the legal arena. It will also evaluate what will need to change in order to alter the prevailing attitudes towards birth in the United States. Part II looks at birth practices and practitioners in the United States, both presently and historically. Part III examines the evidence in favor of and against midwife- rather than physician-attended births. Part IV analyzes regulations restricting the entry and/or scope of practice of CNMs and DEMs throughout the United States. Part V evaluates why DEMs have not been more widely accepted throughout the United States. It concludes that, while midwifery is supported by ample studies showing it to be as safe, if not safer, than physician-supported births for normal, healthy women and fetuses, midwives and their supporters must do more than merely cite statistics if they wish success in more widespread legalization and regulation. Rather, they must strive to bring midwifery into the mainstream – not by capitulating to current medical practice, but by expanding mainstream conceptions of what a normal and healthy birth experience can entail.

## II. BIRTH PRACTITIONERS, PRACTICES AND HISTORY IN THE UNITED STATES

It is important to understand what midwives and other birth attendants do, and what their practice philosophies are, in order to better understand the present debate. There are three primary types of birth attendants employed in the United States today. Physicians –

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<sup>20</sup> See also ROOKS, *supra* note 2, at 114-15 (referring to interviews with and studies of American women who overwhelmingly expressed their preference for delivery by a physician in a hospital). Cf. Martin, *supra* note 16, at 14 (noting that the high majority of hospitals births has been unchanged in the last decades).

<sup>21</sup> See *infra*, section V.

usually obstetricians, but also family practitioners, general practitioners and osteopaths – constitute the largest group.<sup>22</sup> Certified nurse-midwives place a distant second in the number of births attended in the United States.<sup>23</sup> DEMs come third.<sup>24</sup> As we will see, the outcomes achieved with respect to maternal and fetal morbidity and mortality are similar for each group. The philosophies, methods and interventions employed by each group, however, can be quite different.

### A. Physicians

The purpose of modern medicine is the diagnosis and treatment of disease and abnormalities in humans. Obstetrics is no different; its focus “was and remains the diagnosis and treatment of pathology: complications of pregnancy and management of diseases affecting pregnant women and the fetuses they carry.”<sup>25</sup> Given this perspective, obstetricians’ dominant belief that “no case is normal until it is over” is not surprising.<sup>26</sup> A multitude of problems can potentially arise during a birth: for example, the fetus can be malpresented, it can become dangerously entangled in the umbilical cord or suffer respiratory or cardiac distress, a shoulder can become stuck, the uterus can rupture, the perineum can tear severely, or the mother may suffer a pulmonary embolism. The fact that none of these or other complications arise in 90 percent of all births makes no difference to most physicians, who believe one must be as well prepared as possible for the 10 percent of births in which there are problems.<sup>27</sup> Towards this end, physicians who routinely attend childbirths usually make a number of preemptive interventions, such as inserting a needle for an

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<sup>22</sup> Martin, *supra* note 16, at 14.

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> ROOKS, *supra* note 2, at 4.

<sup>26</sup> See, e.g., DEBORAH A. SULLIVAN & ROSE WEITZ, LABOR PAINS: MODERN MIDWIVES AND HOME BIRTH 10, 138 (1988) (citing study results showing 97 percent of polled obstetricians agree with the statement that “[a] physician can never really say who is a low risk obstetrical patient until after the delivery”).

<sup>27</sup> Opinions vary on this matter. See, e.g., DIANA KORTE & ROBERTA M. SCAER, A GOOD BIRTH, A SAFE BIRTH 88 (1992) (citing an obstetrician claiming that 90 percent of all births would be successful even without any birth attendant or intervention); Randi Hutter Epstein, *When Giving Birth, Opting to Go it Alone*, N.Y. TIMES, May 7, 2002, at F5 (citing Dr. Thomas Purdon, the president of ACOG, who claims that 20 percent of previously normal births become complicated during the course of labor or delivery).

IV line in all women who come in for delivery.<sup>28</sup> They also almost universally require that the woman give birth in a hospital.<sup>29</sup>

This philosophy has also led to a progressive increase in obstetrical interventions. While practices such as pre-delivery enemas and perineal shaving have largely been abandoned,<sup>30</sup> and episiotomies (or cuts in the vaginal opening to widen it) are starting to be less preemptively performed in the wake of numerous studies showing their routine use does more harm than good,<sup>31</sup> other interventions such as continuous electronic fetal monitoring, anesthesia, pharmaceutical stimulation of labor and cesarean sections are on the rise.<sup>32</sup> Upon her arrival at the hospital, a laboring woman under physician care will generally be put under a labor management protocol. One widely-used protocol is "active management," in which a woman in active labor is permitted to labor for no more than 12 hours without delivery, whether vaginally or, if necessary, by cesarean section.<sup>33</sup> "Active management" is characterized by routine pelvic examinations to check for cervical effacement and dilation, amniotomy (breaking the bag of waters) when cervical dilation does not progress at a rate of at least 1 cm per hour, and infusion with oxytocin to artificially stimulate labor if "significant progress" does not result from the amniotomy within one hour.<sup>34</sup> Physicians (and hospitals) will also usually restrict a laboring woman's consumption of food or liquids during labor to occasional sips of water or ice chips during the first stage, and nothing thereafter, regardless of the length of labor.<sup>35</sup> Childbirth under a physician's care, then usually means that one spends the greater part of labor in a hospital hooked up to monitors and possibly IV bags, confined to a room or even a bed, deprived of nutrition and significant hydration, and being invasively checked by rotating staff with the prospect of further interventions if one's labor does not progress sufficiently quickly. Although it may be better than what most of our

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<sup>28</sup> See, e.g., WILLIAMS OBSTETRICS 329-30 (20<sup>th</sup> ed. 1997) (an encyclopedia of obstetrics).

<sup>29</sup> WILLIAMS OBSTETRICS 329-30 (20<sup>th</sup> ed. 1997). See ROOKS, *supra* note 2, at 4 (describing the restrictions obstetrics place on women during the birthing process).

<sup>30</sup> Nevertheless, the 20<sup>th</sup> edition of Williams Obstetrics still discusses their use in routine labor management. *But see* WILLIAMS OBSTETRICS 329-30 (20<sup>th</sup> ed. 1997).

<sup>31</sup> See *infra*, notes 126-34 and accompanying text.

<sup>32</sup> See, e.g., Martin, *supra* note 16, at 13-15.

<sup>33</sup> See WILLIAMS OBSTETRICS, *supra* note 28, at 424.

<sup>34</sup> *Id.* at 424-25.

<sup>35</sup> E.g., *id.* at 332, 383.



mothers went through, this method of managing childbirth can render it into a medical, passive and alienating event.

### B. Midwives

Midwives, on the other hand, generally believe that pregnancy and childbirth are normal processes for women, and are trained to approach them as such.<sup>36</sup> In contrast to the “disease-oriented” medical approach, midwives use what some authors have called a “wellness” orientation.<sup>37</sup> As one midwife stated, “Midwives have a . . . strong belief and faith in the natural process and [its] wisdom.”<sup>38</sup> As such, they tend to take a hands-off approach to the management of childbirth, and let labor and delivery progress naturally in most cases. Only where genuine complications arise do midwives tend to intervene in order to change the natural course.<sup>39</sup> As most, if not all, midwives recognize the need for medical intervention where true complications exist, they try to screen out women with high-risk pregnancies early, instead referring them to physicians.<sup>40</sup> Where problems requiring drugs, surgery or medical attention arise during labor, delivery, or in the immediate postpartum period, midwives will transfer the woman or baby to the hospital.<sup>41</sup>

Consistent with the “wellness” approach, midwives tend to treat pregnant and laboring women holistically.<sup>42</sup> Rather than addressing only the pregnancy, midwives attend to the woman herself. As such, they consider the pregnant woman’s social and psychological as well as physical well-being.<sup>43</sup> They believe a woman’s social conditions and psychological status can have significant impact on her pregnancy and birth experience. Their role, therefore, is not merely to intervene in case of complications, but more importantly to provide support to the pregnant and laboring woman.<sup>44</sup> This stands in distinct contrast to

<sup>36</sup> E.g., ROOKS, *supra* note 2, at 5 (distinguishing the practice of midwifery and obstetrics).

<sup>37</sup> See SULLIVAN & WEITZ, *supra* note 26, at 70 (discussing one of the significant differences between midwives physicians).

<sup>38</sup> *Id.*

<sup>39</sup> See *id.* at 71-72 (detailing the passive management style of midwives).

<sup>40</sup> See *id.* at 72 (discussing the role of midwives as risk-screeners).

<sup>41</sup> *Id.*

<sup>42</sup> See *id.* at 75 (discussing the holistic approach of midwives); Rosaline Steele, *Midwifery Care During the First Stage of Labour*, in ASPECTS OF MIDWIFERY PRACTICE: A RESEARCH-BASED APPROACH 26 (Jo Alexander et al. eds., 1995).

<sup>43</sup> See SULLIVAN & WEITZ, *supra* note 26, at 75 (discussing elements of the holistic approach). See also ROOKS, *supra* note 2, at 5 (emphasizing a midwife’s connection to the emotional, spiritual, and ceremonial aspects of the birthing process).

<sup>44</sup> See SULLIVAN & WEITZ, *supra* note 26, at 75-76 (discussing the midwife’s

the role of the physician in childbirth, who generally attends only to medical issues.

In keeping with this role, midwives usually assume a less-hierarchical position in relation to her client than one might find in most physician-patient relationships.<sup>45</sup> Rather than giving a pregnant woman orders, a midwife seeks instead to facilitate healthy pregnancies and deliveries in conjunction with her client.<sup>46</sup> The midwife's role requires the pregnant woman to take more responsibility for her own care and education, as well as for her choices regarding the manner in which she gives birth.<sup>47</sup> It also requires the midwife to deliver more individualized care. She must learn not only about her client's physical progress through pregnancy and labor, but also about her motivations, choices, relationships, and social and economic environment as they impact her pregnancy and motherhood.<sup>48</sup>

Notwithstanding a shared general practice philosophy, as outlined above, there are several different kinds of midwives practicing in the United States today. Midwives throughout the United States differ in their training, accreditation and legal status. They also differ in their primary places of practice (home, hospital or free-standing birthing center) and in the degree of interaction and professional ties they have with the medical profession. Certified nurse-midwives (CNMs) have the highest degree of traditionally accepted medical training. They are registered nurses who have completed further accredited training in midwifery, usually at a master's degree level, and have passed a national certification examination, in addition to meeting other criteria for certification.<sup>49</sup> Properly licensed CNMs may practice legally in every U.S. jurisdiction.<sup>50</sup> Although a very small number perform home births and an even smaller number work at freestanding birthing clinics, CNMs attend almost all of their births in hospitals.<sup>51</sup> In 1994,

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role as counselor); Steele, *supra* note 42, at 35-36, 38-41.

<sup>45</sup> SULLIVAN & WEITZ, *supra* note 26, at 72-74 (discussing the nature of the less hierarchical role of the midwife).

<sup>46</sup> *Id.* at 72-73.

<sup>47</sup> See *id.* at 73 (discussing the patient's duty to take responsibility for her lifestyle while pregnant).

<sup>48</sup> See, e.g., *id.* at 76 (discussing the various aspects of the mother's life involved in individualized care by the midwife).

<sup>49</sup> ROOKS, *supra* note 2, at 7-8.

<sup>50</sup> *Id.* at 8. AMERICAN COLLEGE OF NURSE-MIDWIVES, BASIC FACTS ABOUT CERTIFIED NURSE-MIDWIVES, at <http://www.midwife.org/prof/display.cfm?id=6> (last updated Dec. 12, 2002).

<sup>51</sup> See Sally C. Curtain and Melissa M. Park, *Trends in the Attendant, Place and Timing of Birth, and in the Use of Obstetric Interventions, 1989-1997*, 47 NAT'L

only eight percent practiced through a private nurse-midwifery group, and three percent worked in a freestanding birth clinic.<sup>52</sup> The remaining 89 percent worked for larger health care entities, with the majority employed by physicians or hospitals.<sup>53</sup> As such, most CNMs have strong ties to the medical community, by both training and employment. Also, in most states they are required to practice under either a supervisory or a collaborative relationship with a physician, even if they do not practice in a physician group.<sup>54</sup> It comes as little surprise, then, that in recent years, CNMs have been moving away from a more natural, hands-off approach to childbirth and instead have increasingly been using interventions such as electronic fetal monitoring, labor induction and labor stimulation.<sup>55</sup>

In contrast with CNMs, direct-entry or lay midwives enter the profession through another route than nursing. Their training is varied, as is their legal status from state to state.<sup>56</sup> There are two primary certification programs for DEMs, each of which is controlled by one of the two primary professional associations for midwives in this country. The main one is run by the North American Registry of Midwives (NARM), an offshoot of the Midwives' Association of North America (MANA). The other is administered by the American College of Nurse-Midwives (ACNM). Both programs require certain educational and clinical training, as well as an examination to help verify competence.<sup>57</sup> Certification by one or the other of the programs is either required or accepted as a means of proving one's qualifications in a majority of states that permit practice by DEMs.<sup>58</sup>

Not all DEMs are certified. Rather, some eschew such requirements as irrelevant or even harmful to their practice.<sup>59</sup> Others may avoid certification because they practice illegally in a state that does not permit DEMs to attend births.<sup>60</sup> Still others may wish to become certified, but lack the skills or training to do so.

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CENTER FOR VITAL STATISTICS 2-3 (December 1999).

<sup>52</sup> ROOKS, *supra* note 2, at 8.

<sup>53</sup> *Id.*

<sup>54</sup> *See infra*, section IV, for further discussion.

<sup>55</sup> *See infra*, section III.

<sup>56</sup> *See infra*, section IV.

<sup>57</sup> *E.g.*, ROOKS, *supra* note 2, at 171-72, 251-52 (discussing the controversy and development of certification of direct-entry and lay midwives).

<sup>58</sup> *See, e.g.*, THE NORTH AMERICAN REGISTRY OF MIDWIVES, CPM STATE BOARD CHART, at <http://www.narm.org/stateboardchart.htm> (last updated Jan. 11, 2002) (17 states either require or accept NARM certification).

<sup>59</sup> *See, e.g.*, SULLIVAN & WEITZ, *supra* note 26, at 101-02 (discussing the various fears DEMs have about certification).

<sup>60</sup> *See infra*, section IV.

DEMs, whether certified or uncertified, are less likely than CNMs to have a formal relationship with a physician for backup in case of emergencies.<sup>61</sup> They also predominantly attend planned births in their clients' homes, rather than in the hospital.<sup>62</sup> When attended by a DEM, a laboring woman will usually deliver right in her own house, and remain there with her baby following the delivery. She or her newborn baby will generally only go to the hospital in the unlikely event that a significant complication arises requiring the aid of drugs or surgery.

### C. A Brief History of Birth Attendants in the United States, Today and Historically

The 20<sup>th</sup> edition of *Williams Obstetrics*, the preeminent obstetrical reference text used in the United States, begins with the extraordinary statement that “[w]hen this century began, women delivered their babies at home, prenatal care wan-existent, and specially trained people were unavailable to assist them.”<sup>63</sup> This is not quite correct. For millennia, midwives or lay birth attendants who trained through apprenticeship or experience assisted at most births. Physicians were generally called to births only when the birth was on a disastrous course necessitating the surgical removal of the fetus, usually resulting in the death of the fetus or woman, if not both.<sup>64</sup> The development and use of obstetrical forceps in the early 19<sup>th</sup> century, however, allowed physicians who could use them skillfully the opportunity occasionally to save the lives of both woman and fetus, where death had previously been inevitable.<sup>65</sup> This contributed significantly to the rise of physicians' reputations as birth attendants. The development of anesthetics and aseptic technique and the growing professionalization of medicine added further impetus towards physician-attended births.<sup>66</sup>

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<sup>61</sup> See ROOKS, *supra* note 2, at 294 (explaining that DEMs' criticism of the medical profession has caused this situation).

<sup>62</sup> See Curtain, *supra* note 51, at 3.

<sup>63</sup> WILLIAMS OBSTETRICS, *supra* note 28, at 1.

<sup>64</sup> See, e.g., Richard Johanson et al., *Has the Medicalisation of Childbirth Gone Too Far?*, 324 BRIT. MED. J. 892, 892 (April 2002) (explaining history of men's limited involvement in childbirth prior to the 17<sup>th</sup> century); ROOKS, *supra* note 2, at 11-12.

<sup>65</sup> E.g., ROOKS, *supra* note 2, at 15 (describing the increasing role of doctors over the last two centuries).

<sup>66</sup> See *id.* at 22-23 (listing the social and economic changes that marginalized midwifery at the turn of the century).

By the turn of the 20<sup>th</sup> century, only approximately half of all births in the United States were attended by midwives.<sup>67</sup> Race and class stratified the type of birth attendant that was used, with white middle- and upper-class women making increasing use of physicians in labor and childbirth, and Blacks, immigrants and those with less income tending to use midwives.<sup>68</sup> Through active campaigning on the part of physicians and hospitals to abolish midwifery in the early decades of the 1900's, the stratification by race and class of the use of midwives became even more pronounced.<sup>69</sup> Most obstetricians in the United States were adamantly opposed to midwifery, and wished to see the profession abolished. As one prominent obstetrician noted in 1915:

*The midwife is a relic of barbarism. In civilized countries, the midwife is wrong, has always been wrong. The greatest bar to human progress has been compromise, and the midwife demands a compromise between right and wrong. All admit that the midwife is wrong: It has been proven time and again that it is impossible to make her right . . .*<sup>70</sup>

One strategy was to convince the legislature and the public that childbirth is not a normal act, but instead a pathological one.<sup>71</sup> This effort was successful. Most states decided to subject midwifery to regulation at this time.<sup>72</sup> They ignored, in the process, evidence put forth by proponents of midwifery regarding good pregnancy outcomes in European countries that relied significantly on well-regulated and trained midwives.<sup>73</sup> Eventually, most midwives remained only in

<sup>67</sup> See, e.g., JUDY BARRETT LITOFF, *THE AMERICAN MIDWIFE DEBATE: A SOURCEBOOK ON ITS MODERN ORIGINS* 4-5 (1986) (indicating that approximately 50 percent of all births in the U.S. during the turn of the 20<sup>th</sup> century were by midwives).

<sup>68</sup> *Id.* at 4-5; ROOKS, *supra* note 2, at 26.

<sup>69</sup> See ROOKS, *supra* note 2, at 26 (describing the concern of public health officials that eliminating midwifery would leave some women without access to aid during childbirth).

<sup>70</sup> Joseph B. DeLee, *Progress Toward Ideal Obstetrics*, 6 *TRANSACTIONS AM. ASS'N FOR THE STUDY AND PREVENTION OF INFANT MORTALITY* 114-23 (1915) (reprinted in LITOFF, *supra* note 67, at 102) (emphasis in original).

<sup>71</sup> See, e.g., *id.* at 103-04 ("Engleman says: 'The parturient suffers under the old prejudice that labor is a physiologic act,' and the profession entertains the same prejudice, while as a matter of fact, obstetrics has great pathologic dignity – it is a major science, of the same rank as surgery").

<sup>72</sup> ROOKS, *supra* note 2, at 28.

<sup>73</sup> *Id.* A retrospective review of the medical literature of the late 19<sup>th</sup> and early 20<sup>th</sup> centuries revealed that lay midwives in the United States in fact provided care which was as good as, if not better than, that provided by physicians in labor and delivery. Neal Devitt, *The Statistical Case for Elimination of the Midwife: Fact*

impoverished, rural areas that were poorly served by physicians. Reliance upon midwifery continued to decline thereafter for several decades, with births attended by midwives reaching a record low of 0.5 percent of all deliveries in the early 1970's.<sup>74</sup>

Before the 1930's, when maternal mortality began its dramatic decline, puerperal fever was the leading cause of death in childbirth, accounting for more than 40 percent of all maternal deaths.<sup>75</sup> Maternal mortality was as high as 600-700 deaths per 100,000 in the early decades of the 20<sup>th</sup> century in the United States.<sup>76</sup> The use of antiseptic and aseptic techniques had little effect on the incidence of this problem; rather, it was only when antibiotics such as sulfonamides were introduced that the mortality rates truly started to decline.<sup>77</sup> Other factors cited in the decline of childbirth mortality include the use of "ergometrine, blood transfusions, and penicillin; better training; better anesthesia; improved organization of obstetric services; [and] less interference in normal labors."<sup>78</sup>

Interestingly, maternal mortality declined at a remarkably similar rate in most western countries. One study found that while in 1930, mortality ranged from 250 maternal deaths per 100,000 in the Netherlands to 700 per 100,000 in the United States, by 1960 maternal deaths had declined to about 60 per 100,000 in both countries.<sup>79</sup> It is not merely the dramatic and simultaneous decline in mortality that is interesting, though. Rather, each country had very different birth practices during the period in question. In the Netherlands, the majority of women delivered their babies at home with the help of a midwife. In the United States, on the other hand, the majority of births took place in hospitals under the direction of an obstetrician or other physician.<sup>80</sup> The Netherlands, with its midwife-based practice, started with a better maternal mortality rate than the United States and enjoyed a rapid decline in that rate at the same time as the United States. This suggests that the type of birth attendant used in each

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*Versus Prejudice*, 1890-1935, 4 WOMEN & HEALTH 81, 170-71 (1979).

<sup>74</sup> LITOFF, *supra* note 67, at 14. See, e.g., ROOKS, *supra* note 2, at 60 (discussing the increase of out-of-hospital births in the 1970s).

<sup>75</sup> Irvine Loudon, *Maternal Mortality in the Past and Its Relevance to Developing Countries Today*, 72 AM. J. CLIN. NUTRITION 241S, 241S (July 2000).

<sup>76</sup> *Id.* at 243S tbl. 1.1.

<sup>77</sup> Loudon, *supra* note 75, at 242S, 243S.

<sup>78</sup> *Id.* at 243S.

<sup>79</sup> *Id.*

<sup>80</sup> See ROOKS, *supra* note 2, at 31 (noting the different methods accounting for declines in maternal mortality rates throughout western industrialized nations). See also Loudon, *supra* note 75, at 242S-243S (noting differences in attendant care between the United States and northwestern European countries).

country had little to do with the dramatic decline in mortality touted in this country as the result of obstetric practice.<sup>81</sup>

It further appears that the countries that started with the highest rates of maternal mortality also had the highest rates of physician as opposed to midwife-attended births. Not only did physician-attended births more frequently take place in the hospital, where infections were more likely to occur, but they also more frequently involved surgical procedures with all their attendant complications, even in “normal” deliveries.<sup>82</sup> One researcher cites the example of a renowned American obstetrician, Joseph B. DeLee, who advocated significant surgical interference as a matter of course in ordinary deliveries in the first half of the 20<sup>th</sup> century. In his “prophylactic forceps operation,” Dr. DeLee advocated that every woman should be anesthetized in the second stage of labor (after the cervix is fully dilated and the woman is pushing the fetus out). The physician should then deliver the fetus using forceps and manually remove the placenta.<sup>83</sup> According to the researcher, routine use by other physicians of Dr. DeLee’s prophylactic forceps operation resulted in “horrendous examples of iatrogenic mortality.”<sup>84</sup>

During the same time in the United States, when women had access to continuing prenatal care and delivery by well-trained and experienced midwives with physician backup, maternal and fetal outcomes were far superior to those achieved by physicians. A Metropolitan Life Insurance study of the Frontier Nursing Service, begun in 1925 in rural Kentucky to deliver midwifery services to the impoverished residents of that region, found that there had been no maternal deaths in the first 1,000 deliveries. The study’s author wrote that “[i]f such service were available to the women of the country generally, there would be a saving of 10,000 mothers’ lives a year in the United States. There would be 30,000 less stillbirths and 30,000 more children alive at the end of the first month of life.”<sup>85</sup> The finding is particularly remarkable in light of the abject poverty in which most of the region’s women lived. Poor nutrition, water,

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<sup>81</sup> See Loudon, *supra* note 75, at 244S, 246S (noting that other causes, like the use of antibiotics, caused convergence in mortality rates).

<sup>82</sup> *Id.* at 242S-243S. See also ROOKS, *supra* note 2, at 25-26 (for a description of the surgical procedures recommended for use in physician-attended births).

<sup>83</sup> Loudon, *supra* note 75, at 242S-243S.

<sup>84</sup> *Id.* at 243S.

<sup>85</sup> ROOKS, *supra* note 2, at 37.

housing and sanitation tend to correlate with greater maternal and fetal morbidity and mortality, rather than less.<sup>86</sup>

Midwifery started to resurge among urban, suburban and middle class women during the social movements of the 1970's.<sup>87</sup> However, although midwifery has made slow but steady gains over the past few decades, physicians still attend the vast majority of births in the United States. In 2000, 91.6 percent of all births were physician-attended.<sup>88</sup> An even greater number – more than 99 percent in 2000 – take place in the hospital.<sup>89</sup> Midwives attended only 7.8 percent of all United States births in 1997.<sup>90</sup> Yet this small percentage represents a significant increase over the 3.7 percent attended by midwives in 1989.<sup>91</sup> Certified nurse-midwives accounted for almost all midwife-assisted births.<sup>92</sup> Moreover, almost all births attended by CNMs took place in hospitals.<sup>93</sup> DEMs attended only 5 percent of the midwife-assisted births, or a mere 0.4 percent of all births in the United States in 2000.<sup>94</sup>

### III. MIDWIFE VERSUS PHYSICIAN-ATTENDED BIRTHS: THE DATA

If outcomes in terms of maternal and fetal mortality are relatively similar between physicians, CNMs and DEMs, it may seem irrelevant who acts as a woman's birth attendant. Survival is not, however, the only significant indicator of a successful birth. Morbidity – injury or harm to woman or fetus, whether temporary or permanent – is of course also significant. Other, less tangible, factors are also important. For example, birth should, to the greatest extent possible, promote or at least not hinder the formation of a strong bond between the mother and newborn baby. Towards that end, the mother and child should ideally be sufficiently awake, alert and comfortable following parturition to interact. A mother should be able to breast-

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<sup>86</sup> *E.g., id.* at 31. This is not to say that all studies comparing any group of midwife-attended versus physician-attended births reported better outcomes for the midwife-attended group. In many areas, client poverty, possibly in conjunction with poor performance on the part of some ill-trained midwives, led to higher levels of stillbirth and infant mortality in comparison with physician-attended cohorts. *Id.* at 29.

<sup>87</sup> LITOFF, *supra* note 67, at 14. *See, e.g.,* ROOKS, *supra* note 2, at 46.

<sup>88</sup> Martin, *supra* note 16, at 14.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Id.*

<sup>92</sup> Martin, *supra* note 16, at 14.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*



feed her baby immediately following birth, and spend time together undisturbed. Some would further argue that a woman should feel that she had control over her birthing experience, as it may improve a woman's start to motherhood and may promote a healthy mother-child bond.<sup>95</sup> Depending on the type of childbirth attendant used, a woman has a greater or lesser chance of attaining these goals.

Today, the primary causes of maternal mortality have changed significantly from those in the first half of the 20<sup>th</sup> century and before. In descending order, *Williams Obstetrics* presently lists them as pulmonary embolism, "indirect causes," pregnancy-induced hypertension, ectopic pregnancy, hemorrhage, stroke, anesthesia, abortion, cardiomyopathy and infection.<sup>96</sup> The "indirect causes" are not identified. The causes of neonatal mortality have also changed. Today, the greatest cause of neonatal deaths is preterm delivery and low birth weight.<sup>97</sup> In 1999, these accounted for 23.1 percent of all neonatal deaths, followed by congenital abnormalities at 20.8 percent.<sup>98</sup> The remaining top causes, including the following in descending order, altogether accounted for slightly over 30 percent of neonatal deaths in 1999: maternal complications of pregnancy, respiratory distress, complications of placenta, cord or membranes, bacterial sepsis, intrauterine hypoxia and birth asphyxia, neonatal hemorrhage and necrotizing enterocolitis.<sup>99</sup> "Other" causes accounted for the remaining 23.2 percent of deaths.

Notably, only a minority of the present causes of maternal and neonatal mortality can be significantly ameliorated by any of the most common interventions used by obstetricians today. Correspondingly, most studies show that midwives, who generally perform fewer interventions than obstetricians, have favorable rates of both maternal and neonatal morbidity and mortality in comparison with physicians, at least with respect to low-risk births. Most studies comparing outcomes for midwife-attended home births in comparison with births taking place in hospitals, where maternal and socioeconomic risk factors were controlled, have found little difference in both maternal

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<sup>95</sup> See, e.g., ROOKS, *supra* note 2, at 342 (discussing the underlying empowerment objective of midwifery).

<sup>96</sup> WILLIAMS OBSTETRICS, *supra* note 28, at 4. See also CDC, *Achievements in Public Health, 1900-1999: Healthier Mothers and Babies*, 48 MORBIDITY & MORALITY WEEKLY REP. 849 (1999).

<sup>97</sup> Robert N. Anderson, *Deaths: Leading Causes in 1999*, 49 NAT'L VITAL STAT. REP. Oct. 11, 2001, at 11-12, available at [http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49\\_11.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_11.pdf).

<sup>98</sup> *Id.* at 11-12.

<sup>99</sup> *Id.* at 12.

and neonatal morbidity and mortality.<sup>100</sup> In fact, one study of over 1,700 low-risk home deliveries attended by midwives trained at The Farm in Tennessee found, after controlling for various risk factors, that the midwife-attended group fared better than those who gave birth in a hospital attended by a physician with respect to perinatal death, low five-minute Apgar scores, labor complications, and assisted delivery.<sup>101</sup> As one researcher said, "No one can tell a mother she is perfectly safe giving birth at home. Whether she is safer at home than in a hospital, however, is another question."<sup>102</sup>

Midwives may also do better than physicians with respect to certain outcome measures when practicing in the hospital. Studies comparing CNM versus physician-attended hospital births found either comparable outcomes in terms of maternal and neonatal morbidity and mortality, or superior outcomes for the midwife-attended groups.<sup>103</sup> In fact, one large retrospective study examining

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<sup>100</sup> See, e.g., Lewis E. Mehl et al., *Outcomes of Elective Home Births: A Series of 1,146 Cases*, 19 J. REPROD. MED. 281, 290 (1977) (noting that home delivery is usually a safe alternative); Lewis Mehl et al., *Evaluation of Outcomes of Non-Nurse Midwives: Matched Comparisons with Physicians*, 5 WOMEN'S HEALTH 17-29 (1980); M. Ward Hinds et al., *Neonatal Outcome in Planned v Unplanned Out-of-Hospital Births in Kentucky*, 253 JAMA 1578 (1985) (comparing mortality rates in planned home deliveries versus unplanned home deliveries and finding little significance in differences); A. Mark Durand, *The Safety of Home Birth: The Farm Study*, 82 AM. J. PUB. HEALTH 450, 451-52 (1994) (discussing the relative safety of home births); Patricia A. Janssen et al., *Licensed Midwife-Attended, Out-of-Hospital Births in Washington State: Are They Safe?*, Abstract, 21 BIRTH 141, 141-48 (1994) (comparing neonatal morbidity and mortality). But see Jenny W.Y. Pang et al., *Outcomes of Planned Home Births in Washington State: 1989-1996*, 100 OBSTETRICS & GYNECOLOGY 253 (2002), available at [http://www.acog.org/from\\_home/publications/green\\_journal/wrapper.cfm?document=2002/ong13594fla.htm](http://www.acog.org/from_home/publications/green_journal/wrapper.cfm?document=2002/ong13594fla.htm) (finding that "planned home births in Washington State during 1989-1996 had greater infant and maternal risks than did hospital births").

<sup>101</sup> Durand, *supra* note 100, at 452 tbl. 4.

<sup>102</sup> JENNIFER L. GRIEBENOW, HOME BIRTH AND OUT-OF-HOSPITAL BIRTH: IS IT SAFE?, at <http://www.gentlebirth.org/ronnie/homejgg.html> (last visited Aug. 7, 2002). See also MARSDEN WAGNER, *Technology in Birth: First Do No Harm*, MIDWIFERY TODAY, at <http://www.midwiferytoday.com/articles/technologyinbirth.asp> (last visited Aug. 8, 2002) (discussing risks of childbirth despite increasing use of technology).

<sup>103</sup> See, e.g., Kathleen Carrigan Kelcher & Leon I. Mann, *Nurse-Midwifery Care in an Academic Health Center*, 15 J. OBSTETRIC GYNECOLOGIC, & NEONATAL NURSING 369 (1986) (finding that "CNM care is a safe, cost-effective, and sought after alternative to MD-only care"); Deborah Oakley et al., *Comparisons of Outcomes of Maternity Care by Obstetricians and Certified Nurse-Midwives*, 88 OBSTETRICS & GYNECOLOGY 823, 823-29 (1996) (showing differences in outcomes in certain areas, mostly favoring CNMs); Marian F. MacDorman & Gopal K. Singh, *Midwifery Care, Social and Medical Risk Factors, and Birth Outcomes in the USA*, 52 J. EPIDEMIOL. COMMUNITY HEALTH 310 (1998) (studying the differences in birth outcomes and

physician versus CNM-attended births in the United States in 1991 found that, after controlling for medical and socioeconomic risk factors, the midwife cohort was 19 percent less likely to experience infant death and the risk of neonatal mortality was 33 percent lower than that experienced by the physician cohort.<sup>104</sup>

While outcome measurements are quite similar between direct-entry certified nurse midwife and physician-attended low-risk births, DEMs (and in some cases CNMs)<sup>105</sup> perform distinctly better than physicians in keeping their intervention rates down. As noted above, most obstetrical interventions during labor and delivery have little, if any, effect on the majority of the causes of maternal and neonatal morbidity and mortality. Moreover, they are costly, both in their own right and in the cascade of subsequent interventions to which the use of some can lead.<sup>106</sup> For example, cesarean sections were performed in 22.9 percent of all births in the United States in 2000.<sup>107</sup> The rate of cesarean sections is increasing in the United States,<sup>108</sup> and is significantly higher than that found in most other developed countries.<sup>109</sup> At the same time, our neonatal morbidity and mortality rates are some of the worst among developed nations.<sup>110</sup> These two pieces of data suggest that we may be performing too many caesarean sections without proper indication, and that the high rate of caesareans may not be justified in terms of neonatal outcome.<sup>111</sup>

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survival of infants delivered by midwives compared to physicians).

<sup>104</sup> MacDorman, *supra* note 104.

<sup>105</sup> It appears that CNMs, who practice most often in hospitals, have been increasing the rate of many interventions they perform and, in fact, perform almost as many of some interventions as do physicians. Sally C. Curtain, *Recent Changes in Birth Attendant, Place of Birth, and the Use of Obstetric Interventions, United States, 1989-1997*, 44 J. NURSE-MIDWIFERY 349, 349, 352 (1999).

<sup>106</sup> It is paradoxical that we regularly waste large sums of money on unnecessary obstetrical interventions when a sizeable portion of our population cannot even afford basic prenatal care. See, e.g., Mary Gabay & Sidney Wolfe, *The Beneficial Alternative*, 112 PUB. HEALTH REP. 386 (1997).

<sup>107</sup> Martin, *supra* note 16, at 72.

<sup>108</sup> *Id.* at 2.

<sup>109</sup> See generally ROOKS, *supra* note 2, at 393-446 (for a discussion of midwifery practices in European and other developed countries and how these practices have affected the rate of cesarean sections in those countries).

<sup>110</sup> See, e.g., Lindsay A. Thompson et al., *Is More Neonatal Intensive Care Always Better? Insights from a Cross-National Comparison of Reproductive Care*, 109 PEDIATRICS 1036 (2002) (showing the neonatal mortality rate in the United States to be 7.1 per 1,000, in comparison with 4.3-5.5 for the other countries studied).

<sup>111</sup> See, e.g., ROOKS, *supra* note 2, at 314-15 (discussing the lack of positive outcomes from electronic fetal monitoring and cesarean sections versus vaginal births). See also Elizabeth Shearer, *Cesarean Section: Medical Benefits and Costs*, 37 SOC. SCI. & MED. 1223-31 (1993) (discussing the potential benefits of cesarean).

Excessive cesarean sections are problematic. Women die from anesthetic accidents, hemorrhage and infection due to cesareans.<sup>112</sup> Moreover, not only are cesareans more expensive than vaginal deliveries, but they also lead to significantly increased maternal morbidity.<sup>113</sup> Cesareans are major abdominal surgery. They can lead to problems such as hemorrhage, urinary tract infection and nonfatal complications of blood clots.<sup>114</sup> Recovery is painful and takes weeks. Because of the tension it puts on the abdominal incision, lifting objects weighing more than several pounds – including one's new baby – results in increased pain and may in fact be prohibited by one's physician. The pain from tissues damaged in the operation also interferes with successful breastfeeding. Contrary to popular belief, cesarean sections are also not wholly risk-free to the fetus, as they can lead to neonatal birth trauma such as Erb's palsy (a nerve injury that results in problems moving the shoulder)<sup>115</sup> and fractures.<sup>116</sup>

Numerous studies have found that midwives – both CNMs and direct entry – have a significantly lower rate of cesarean sections among their clients than do women of similar risk status who are attended by physicians.<sup>117</sup> Studies showing that women attended by midwives have half the cesarean section rate or even less of similar women attended by physicians are not uncommon.<sup>118</sup> Note that these studies all involve women who were identified as "low risk," and therefore appropriate candidates for either midwife or physician care

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<sup>112</sup> WILLIAMS OBSTETRICS, *supra* note 28, at 514.

<sup>113</sup> *See, e.g., id.* at 514-15 (discussing maternal mortality associated with cesarean section and vaginal births).

<sup>114</sup> *Id.* at 515.

<sup>115</sup> *See* THE MERCK MANUAL OF DIAGNOSIS AND THERAPY 1768 (Robert Berkow et al. eds., 14<sup>th</sup> ed. 1982).

<sup>116</sup> *See, e.g.,* WILLIAMS OBSTETRICS, *supra* note 28, at 515 (discussing birth trauma associated with cesarean section).

<sup>117</sup> *See, e.g.,* Keleher & Mann, *supra* note 103, at 372 (finding a five-percent reduction in cesarean sections when using midwives as opposed to physicians); William Fraser et al., *Comparison of Midwifery Care to Medical Care in Hospitals in the Quebec Pilot Projects Study: Clinical Indicators*, 91 CAN. J. PUBLIC HEALTH 15-11 (2000) (comparing process and outcomes of midwifery services and physician services); Janssen, *supra* note 100; Durand, *supra* note 100, at 452 tbl. 4 (finding that midwives in the farm group performed cesarean sections at a lower rate than hospital births).

<sup>118</sup> *See, e.g.,* Keleher & Mann, *supra* note 103; Patricia A. Janssen et al., *Outcomes of Planned Home Births Versus Planned Hospital Births After Regulation of Midwifery in British Columbia*, 166 CAN. MED. ASS'N J. 315, 317 (2002) (examining rates of cesarean section among women using different interventions in labor); Durand, *supra* note 100, at 452 tbl. 4 (finding that in this study, the incidence of cesarean sections was more than ten times more likely in hospital births than in midwife-assisted births in the farm group).

in pregnancy and delivery. The low caesarean section rate that midwives enjoy is thus not substantially attributable to their choice of low-risk clients. It also does not appear to jeopardize maternal or neonatal health in any way.<sup>119</sup> Finally, it is cost-effective, as deliveries involving a caesarean section cost thousands of dollars more and require longer hospitalizations than do most vaginal deliveries.

Midwives' clients have lower rates of epidural use than do women attended by physicians. It is well known that childbirth can be extremely painful. An epidural is anesthesia administered in the spine which blocks sensation in the pelvis and legs. It allows a laboring woman to obtain pain relief yet remain conscious during delivery and obviates the need for systemic anesthesia, which can lead to fetal neurological depression.<sup>120</sup> Epidural anesthesia, however, increases the likelihood of fetal distress.<sup>121</sup> Where the likelihood of fetal distress is increased, continuous electronic fetal monitoring (EFM) rather than intermittent fetal heart rate monitoring is necessitated.<sup>122</sup> EFM can lead to increased caesarean section rates, due to an increased collection of data suggesting fetal distress as compared with intermittent monitoring.<sup>123</sup> Epidurals also increase the need for stimulation of labor, episiotomies, and delivery with forceps, as they can decrease the vigor of contractions and the ability of the woman to spontaneously expel the fetus.<sup>124</sup> The clients of both DEMs and CNMs have significantly lower epidural use rates than do laboring women attended by physicians.<sup>125</sup>

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<sup>119</sup> See Keleher & Mann, *supra* note 103, at 372 (noting that midwife care, with its reduced cesarean section rates, has proven to be safe for newborns and their mothers); Janssen, *supra* note 118, at 322 (noting that births outside of hospitals do not result in an increased incidences of "adverse neonatal outcomes"); Durand, *supra* note 100, at 451-52 (finding that in addition to the low incidence of cesarean sections in the midwife group, no increase in maternal or neonatal harm was found).

<sup>120</sup> See ROOKS, *supra* note 2, at 316 (discussing the risks and benefits associated with the use of epidural anesthesia).

<sup>121</sup> See *infra*, notes 136-37 and associated text for a definition of fetal distress.

<sup>122</sup> ROOKS, *supra* note 2, at 316.

<sup>123</sup> See *infra*, note 139 and accompanying text.

<sup>124</sup> ROOKS, *supra* note 2, at 316.

<sup>125</sup> See, e.g., Oakley, *supra* note 103 (19.7 percent versus 44.5 percent); Roger A. Rosenblatt et al., *Interspecialty Differences in the Obstetric Care of Low-Risk Women*, 87 AM. J. PUB. HEALTH 344, 347 (1997). *But see* Janssen, *supra* note 118, at 319 (finding that midwives attending hospital births had an epidural rate that was almost equal to that of physicians – 26.3 percent as compared with 27.6 percent, respectively). Note that British Columbia (and the rest of Canada), where Janssen's study took place, does not distinguish between types of midwives based on their training, as the United States does.

An episiotomy is a deliberate incision made to enlarge the opening of the vagina. Physicians make a cut, usually from the bottom of the vaginal opening down towards the rectum (median episiotomy) or, less frequently, diagonally towards a point to one side of the rectum (mediolateral episiotomy).<sup>126</sup> Episiotomies are intended to help preserve the pelvic floor, by preemptively making a clean incision rather than allowing the fetus' head to tear the tissue raggedly as it comes through, and by helping to prevent overstretching of the muscles of the pelvic floor.<sup>127</sup> They also are used to help prevent trauma to the fetus' head and speed up delivery in the event of fetal distress, and to enlarge the vaginal opening for forceps use.<sup>128</sup> Numerous studies, however, have shown that routine use of episiotomies yields no benefits to either women or fetuses.<sup>129</sup> Rather, median episiotomies, when used routinely, are associated with a higher risk of anal incontinence and severe tears.<sup>130</sup> The clients of both DEMs and CNMs underwent episiotomies far less frequently than did women attended by physicians.<sup>131</sup> Moreover, studies have

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<sup>126</sup> ROOKS, *supra* note 2, at 322.

<sup>127</sup> *Id.*

<sup>128</sup> *Id.* Forceps use is also problematic if used unnecessarily, as it results in higher rates of vaginal and pelvic injury to women and head lacerations to fetuses than does unassisted vaginal delivery. See, e.g., Barbara Bodner-Adler et al., *Risk Factors for Third-Degree Perineal Tears in Vaginal Delivery, with an Analysis of Episiotomy Types*, 46 J. REPROD. MED. 752, 755 (2001) (finding a "significant higher rate of . . . perineal tears in women who delivered with the aid of forceps as compared to normal vaginal deliveries"); C. MacArthur et al., *Obstetric Practice and Faecal Incontinence Three Months After Delivery*, BRIT. J. OBSTETRICS & GYNECOLOGY 678, 681-82 (2001) (finding that the use of forceps during delivery increases the rate of faecal incontinence); S. Meyer et al., *Birth Trauma: Short and Long Term Effects of Forceps Delivery Compared with Spontaneous Delivery on Various Pelvic Floor Parameters*, 107 BRIT. J. OBSTETRICS & GYNECOLOGY 1360, 1363 (2000) (noting the potential danger with using forceps); J. Brian Greis et al., *Comparison of Maternal and Fetal Effects of Vacuum Extraction with Forceps or Cesarean Deliveries*, 57 OBSTETRICS & GYNECOLOGY 571 (1981).

<sup>129</sup> The seminal study which led to a universal, if gradual, decline in routine episiotomy use, is Stephen B. Thacker & H. David Banta, *Benefits and Risks of Episiotomy: An Interpretive Review of the English Language Literature, 1860-1980*, 38 OBSTETRICAL & GYNECOLOGICAL SURVEY 322 (1983).

<sup>130</sup> Erica Easton et al., *Anal Incontinence After Childbirth*, 166 CAN. MED. ASS'N J. 326, 329-30 (2002). See also Roberto Angioli et al., *Severe Perineal Lacerations During Vaginal Delivery: The University of Miami Experience*, 182 AM. J. OBSTETRICS & GYNECOLOGY 1083, 1083-85 (2000) (explaining potential harmful effects of medical procedures during childbirth).

<sup>131</sup> See ROOKS, *supra* note 2, at 325, 326 tbl.10 (comparing the results of studies between MD and CNM practices in low-risk labor and deliveries). Oakley, *supra* note 103. But see Janssen, *supra* note 118, at 319 (finding that home birth midwives used episiotomy in only 3.8 percent of cases, as compared with 10.9

shown that midwives do better than physicians in supporting a woman's perineum in childbirth.<sup>132</sup> Perineal integrity is improved for clients of birth practitioners who use episiotomies the least often,<sup>133</sup> and rates of severe tears are lower.<sup>134</sup>

Electronic fetal monitoring (EFM) is performed in the vast majority of births in the United States: in 2000, 84 percent of all live births involved continuous electronic fetal monitoring.<sup>135</sup> EFM follows the fetus' heart rate throughout labor and delivery, either through an external band wrapped around the woman's abdomen or through an internal monitor tacked into the fetus's head. A pattern of significant decelerations of the fetal heart rate immediately following contractions is often thought to indicate fetal distress.<sup>136</sup> Fetal distress broadly comprises any danger to the fetus, but frequently involves asphyxia.<sup>137</sup> EFM was the most commonly performed intervention among those followed by the Centers for Disease Control that year. Yet studies have shown that continuous EFM does little, if anything, to materially improve neonatal morbidity and mortality.<sup>138</sup> At the same time, researchers have demonstrated that EFM leads to an appreciable rise in the number of caesarean sections.<sup>139</sup> While at least

percent of cases for hospital midwives).

<sup>132</sup> See, e.g., ROOKS, *supra* note 2, at 320 (finding that women who delivered at home with a midwife had the highest rate of intact perineum following childbirth – 55.0 percent).

<sup>133</sup> Lisa Kane Low et al., *Clinician-Specific Episiotomy Rates: Impact on Perineal Outcomes*, 45 J. MIDWIFERY & WOMEN'S HEALTH 87, 91 (2000).

<sup>134</sup> See, e.g., ROOKS, *supra* note 2, at 325 (summarizing the results from several studies on the occurrence of vaginal lacerations during childbirth).

<sup>135</sup> Martin, *supra* note 16, at 13.

<sup>136</sup> See WILLIAMS OBSTETRICS, *supra* note 28, at 367 (discussing presence of fetal distress in normal human parturition).

<sup>137</sup> *Id.*

<sup>138</sup> See, e.g., Leah Albers, *Monitoring the Fetus in Labor: Evidence to Support the Methods*, 46 J. MIDWIFERY & WOMEN'S HEALTH 366, 366 (2002) (noting that, while EFM "increases the operative delivery rate," it does not benefit the baby); S. Thacker et al., *Continuous Electronic Heart Monitoring for Fetal Assessment DURING LABOR*, COCHRANE DATABASE SYSTEM REV. (2001), available at <http://gateway2.ovid.com/ovidweb.cgi> (last visited Feb. 11, 2003) (finding that continuous EFM resulted in a statistically significant reduction only of neonatal seizures).

<sup>139</sup> See H. David Banta & Stephen B. Thacker, *Historical Controversy in Health Technology Assessment: The Case of Electronic Fetal Monitoring*, 56 OBSTETRICAL & GYNECOLOGICAL SURV. 707, 707 (2001) (suggesting that EFM use has increased cesarean deliveries); WILLIAMS OBSTETRICS, *supra* note 28, at 331. Because of these findings, even the American College of Obstetricians and Gynecologists (ACOG) does not recommend its use in normal labor. Rather, ACOG recommends checking the fetal heart rate following a contraction at least once every half hour, and then every 15 minutes during the second stage of labor. WILLIAMS

one study found that midwives working in hospitals tend to utilize EFM as frequently as physicians,<sup>140</sup> direct-entry and other midwives assisting women to deliver at home do not.<sup>141</sup> Moreover, given that even CNMs practicing in hospitals still have a much lower caesarean section rate than do physicians, it does not presently appear that EFM necessarily leads to harmful results when used by midwives as compared to its use in physician-attended births.

DEMs have lower rates of labor induction and stimulation than do physicians. Gestation prolonged past 41 weeks poses increased risks to the fetus, due to placental deterioration and a decrease in amniotic fluid starting around that time.<sup>142</sup> Also, labor that is genuinely prolonged poses increased dangers to both the pregnant woman and the fetus.<sup>143</sup> Because of these risks, labor induction or stimulation may be warranted in some cases. In labor induction, a physician administers oxytocin, a drug, to artificially make labor begin.<sup>144</sup> In labor stimulation, a physician administers oxytocin or performs an amniotomy in order to speed up labor.<sup>145</sup> Studies have shown that a small number of perinatal deaths can be prevented by labor induction after 41 weeks gestation or by speeding up abnormally slow labor.<sup>146</sup> However, most pregnancies that proceed past 41 weeks are concluded safely for both mother and child,<sup>147</sup> and even obstetricians agree that prolonged labor is overdiagnosed in the United States.<sup>148</sup>

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OBSTETRICS, *supra* note 28, at 330.

<sup>140</sup> Albers, *supra* note 138.

<sup>141</sup> See, e.g., Janssen, *supra* note 118, at 319 (finding the home birth group to have a 14.7 percent EFM rate, as compared with 82.6 percent in the hospital physician group and 58.0 percent in the hospital midwife group).

<sup>142</sup> See WILLIAMS OBSTETRICS, *supra* note 28, at 830 (discussing placental dysfunction and deterioration).

<sup>143</sup> See, e.g., ROOKS, *supra* note 2, at 318 (identifying risks associated with prolonged labor).

<sup>144</sup> See *id.* at 311-12 (noting the FDA ban on non-medically necessary use of oxytocin to induce labor).

<sup>145</sup> See *id.* at 318-19 (describing various approaches to active management of labor including the use of oxytocin and performing amniotomies).

<sup>146</sup> *Id.* at 312; 318.

<sup>147</sup> See *id.* at 312 (discussing the findings of a 1995 study by Enkin et al. concerning post-date pregnancies).

<sup>148</sup> See WILLIAMS OBSTETRICS, *supra* note 28, at 422 (discussing overdiagnosis of dystocia to cesarean section). Problematically, physicians have continually shortened the length of what constitutes "normal" labor over recent decades to such a degree that it no longer tracks the true variation in what should be considered normal. See ROOKS, *supra* note 2, at 319 (quoting researchers as questioning "whether the criteria used to define 'normal' adequately reflect the actual variations in labour patterns among women"); L. Albers, *The Duration of Labor in Healthy Women*, 19 J. PERINATOLOGY 114-19 (1999).



Nevertheless, the rates of both induction and stimulation of labor have risen steadily in recent years.<sup>149</sup> This is problematic, as neither are benign interventions. Both can lead to increased fetal distress and birth trauma.<sup>150</sup> They also make contractions more painful, leading to a higher use of anesthetics,<sup>151</sup> and more frequently result in caesarean sections.<sup>152</sup> DEMs have significantly lower induction and stimulation rates than physicians.<sup>153</sup> The rates for DEMs are lower than those for CNMs, which have been rising in recent years and now approach those of physicians.<sup>154</sup>

#### IV. THE LEGAL STATUS OF MIDWIFERY THROUGHOUT THE UNITED STATES

Given the data comparing midwife- versus physician-attended births, including planned home births, one would think that a rational state legislature would enact laws permitting not merely CNMs but also DEMs to practice more freely. A rational state might reasonably limit midwives' practice to uncomplicated deliveries. It might or might not permit midwives to obtain and use drugs to stop hemorrhage or for other purposes. A rational state ought not, however, to exclude DEMs from attending most births, or require mandatory physician supervision of CNMs and DEMs, given the data.

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<sup>149</sup> See, e.g., T. Matthews, *Trends in Stimulation and Induction of Labor 1989-1995*, 78 STAT. BULL. 20 (1997) (reporting the rising rate of stimulation and induction of labor in the U.S. between 1989-1995).

<sup>150</sup> See, e.g., ROOKS, *supra* note 2, at 313, 319-20 (stating EFM is necessary to monitor fetal distress and use of oxytocin increased the rate of admissions to the neonatal intensive care unit).

<sup>151</sup> See *id.* (stating that oxytocin strengthens the intensity of the contractions resulting in more pain to the mother).

<sup>152</sup> E.g., WILLIAMS OBSTETRICS, *supra* note 28, at 422 (discussing overdiagnosis of dystocia leading to cesarean section); Matthews, *supra* note 149.

<sup>153</sup> See, e.g., Janssen, *supra* note 118, at 319 (noting that midwives in either home births or hospital births have lower induction and augmentation rates than physicians). Note that while DEMs are permitted to administer oxytocin in only certain jurisdictions, some use herbs to induce or stimulate labor, or suggest nipple stimulation or other activities to increase the pregnant woman's own oxytocin production.

<sup>154</sup> See Curtin, *supra* note 105, at 352-53 (noting that only a slight difference exists between the induction and stimulation rates for physicians and midwives). See also Oakley, *supra* note 103 (noting an identical rate of labor stimulation (11.3 percent) and nearly identical induction rate (15.1 for nurse-midwives and 17.1 percent for physicians)); Janssen, *supra* note 118, at 319 (noting that home birth midwives used an amniotomy in 15.8 percent of cases and oxytocin in 6.4 percent of cases to augment labor, as compared with 37.0 percent and 16.8 percent in the hospital physician group and 27.1 percent and 19.1 percent in the hospital midwife group, respectively).

Nor ought it to require women with uncomplicated pregnancies to give birth in hospitals if they wish to be attended by a midwife who is practicing lawfully. Yet when we look at present regulations, this is not uniformly what we find.

#### A. Regulation of Certified Nurse-Midwifery

Presently, states vary widely in the degree of regulation to which they subject midwifery. As noted above, all fifty states permit certified nurse-midwives to practice.<sup>155</sup> However, many states limit the authority of their practice by requiring physician supervision of their work.<sup>156</sup> Such laws are often an artifact of lumping nurse-midwives in along with all other advanced practice nurses, such as nurse-practitioners.<sup>157</sup> Other states require merely a “collaborative” relationship between CNMs and physicians.<sup>158</sup> In such states, rather than being subjected to physician oversight on all of their cases, CNMs are often merely required to have a working relationship with a physician with whom they may confer, and to whom they may refer complicated cases.<sup>159</sup> States may also limit the scope of nurse-midwives’ practice by limiting the means by which they may assist at births. For example, California prohibits CNMs from using “any artificial, forcible, or mechanical means” of delivery, including methods by which a fetus in a breech presentation may be turned to facilitate birth.<sup>160</sup> This is a common prohibition.

Physician supervision requirements can be quite arduous. It is not merely that a supervised midwife has a physician looking over her shoulder. Rather, many if not most state statutes mandating physician

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<sup>155</sup> See *supra*, note 50 and accompanying text.

<sup>156</sup> See, e.g., CAL. BUS. & PROF. CODE § 2764.5(a) (2001) (“The certificate to practice nurse-midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn”).

<sup>157</sup> See, e.g., 225 ILL. COMP. STAT. 65/15-5 (2002) (categories of advance practice nurses include “certified nurse midwife (CNM), certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), or certified clinical nurse specialist (CNS)”).

<sup>158</sup> See, e.g., ALA. CODE § 34-21-81(3) (2002) (“Certified registered nurse practitioners and certified nurse midwives are subject to collaborative practice agreements with an Alabama physician”).

<sup>159</sup> See, e.g., COLO. REV. STAT. § 12-38-111.5(6) (2002) (“A certified nurse-midwife shall practice in accordance with the standards of the American college of nurse-midwives including, but not limited to, having a safe mechanism for consultation or collaboration with a physician or, when appropriate, referral to a physician”).

<sup>160</sup> CAL. BUS. & PROF. CODE § 2746.5(b) (2001).

supervision leave the definition of “supervision” ambiguous.<sup>161</sup> Thus, the manner and degree of supervision may vary dramatically from physician to physician, and leave midwives potentially subject to more medical requirements and oversight than they would otherwise use if left to themselves.<sup>162</sup> On the one hand, while many physicians may object to midwifery, those who would agree to supervise a midwife are probably less likely to have significant problems with the practice than other doctors. It is equally unlikely that a midwife would agree to be supervised by a physician who has fundamental objections to her craft or profession.<sup>163</sup> On the other, it is possible that some physicians may agree to supervise midwives under the theory that it is better to benefit from some of the work they do and to have some control over their practice than to risk losing that control and finding instead, one day, that the midwife has become one’s independent competitor.<sup>164</sup> Toward that end, the American Academy of Family Practitioners, for example, officially advocates that physicians should supervise midwives (and all other non-physician health care providers), and that all payments for midwives’ services should go through the supervising physician.<sup>165</sup>

Regulations that mandate physician supervision also effectively put the supervising physician on the hook, legally, for the midwife’s actions. The threat of legal liability means a supervising physician is more likely to restrict a midwife’s activities and generally to be more cautious, not necessarily for philosophical or medical reasons, but instead for fear of being sued. This is not an idle fear. Even if a physician and the midwife she is supervising have the same insurance limits, the physician may legitimately be perceived as a “deeper pocket” than the midwives, given the significant disparity between physicians’ and midwives’ incomes.<sup>166</sup> The physician’s medical malpractice insurance carrier may also put restrictions on the scope of

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<sup>161</sup> See, e.g., Gabay, *supra* note 106 (discussing the restrictions on midwife authority).

<sup>162</sup> *Id.*

<sup>163</sup> Midwives differ in whether they wish to term midwifery a “craft” or a “profession.” This debate often parallels that regarding licensure.

<sup>164</sup> See, e.g., ROOKS, *supra* note 2, at 83-84 (noting dissent among obstetricians over the American College of Obstetricians and Gynecologists’ joint statement with the American College of Nurse-Midwives asserting that “quality of care is enhanced by the *interdependent* practice of obstetrician-gynecologists and CNMs”) (emphasis in original).

<sup>165</sup> *Id.* at 83.

<sup>166</sup> See, e.g., SULLIVAN & WEITZ, *supra* note 26, at 162-63 (noting that only 4 out of the 50 midwives interviewed reported on income of more than \$10,000 per year in the early 1980s).

midwifery practice that she can supervise without losing her coverage, or may refuse to cover such supervision altogether.<sup>167</sup> And even if a midwife finds a physician who is willing to “supervise” her practice by using a hands-off approach, the CNM is still subject to the indignity of having been deemed by law to be insufficiently competent to be responsible for her own practice.

Laws requiring collaboration seem to make more sense than those mandating supervision. While midwives perform as well as, if not better than, obstetricians in normal deliveries, at least one study has shown that midwives fare decidedly worse than physicians when certain complications are present. Lewis Mehl-Madrona et al. performed a retrospective study of 1,000 home births attended by apprentice-trained direct entry midwives and 1,000 physician-attended hospital births, matched for age, socioeconomic status, race, and medical risk.<sup>168</sup> The study found that home births involving post-dates, twin, or breech deliveries were 3.1 times as likely to have resulted in neonatal death as those that took place in a hospital.<sup>169</sup> The authors conclude that while midwife-attended home births are appropriate for normal pregnancies and deliveries, high-risk births are safer in the hospital under physician supervision.<sup>170</sup> As not all women who desire midwifery services have low-risk pregnancies, and because not all low-risk pregnancies remain low-risk through delivery, it would arguably be beneficial for midwives to have a collegial relationship with at least one practicing physician whom they can consult about cases and, if appropriate, refer clients who are not suitable for midwifery care.

Laws mandating collaboration between midwives and physicians, however, may sometimes yield the same results as those requiring physician supervision. As we saw above with respect to the statutory definitions of “supervision,” the definition of “collaborate” is usually left undefined. Thus, it is uncertain whether relevant statutes intend for midwives to have an informal, collegial relationship with one or more physicians, with whom they can consult, or whether they intend

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<sup>167</sup> See AMERICAN COLLEGE OF DOMICILIARY MIDWIVES (hereinafter ACDM), PUBLIC HEARING BEFORE THE MEDICAL BOARD OF CALIFORNIA, DIVISION OF LICENSING (Feb. 7, 1997), available at [http://www.goodnewsnet.org/legal\\_legislative01/testmbc.htm](http://www.goodnewsnet.org/legal_legislative01/testmbc.htm) (stating that malpractice insurers disfavor this relationship because the “physician is ultimately responsible for the patient”).

<sup>168</sup> Lewis Mehl-Madrona & Morgaine Mehl Madrona, *Physician and Midwife-Attended Home Births. Effects of Breech, Twin and Post-Dates Outcome Data on Mortality Rates*, 42 J NURSE MIDWIFERY 91 (1997).

<sup>169</sup> *Id.* at 95.

<sup>170</sup> *Id.* at 97.

a more formal relationship, in which they are required to coordinate their care with physicians. Unsurprisingly, it appears that at least some physicians would prefer the latter. In 1993, the American College of Obstetrician-Gynecologists (ACOG) issued a revised joint statement with the American College of Nurse-Midwives in support of collaborative practice between obstetricians and CNMs.<sup>171</sup> As one obstetrician who commented on the statement noted, “[c]ollaborative practice makes the best use of the knowledge and skills of physicians and non-physician providers, each working within his or her scope of practice, using mutually agreed upon guidelines and policies that define the role and shared responsibilities of each provider.”<sup>172</sup> Yet it is clear that the commentator meant not merely that midwifery and obstetrics can complement each other, but that midwives ought further to be part of a practice group with obstetricians. Such an arrangement, the obstetrician noted, allows for different types of expertise to “be readily available as the need arises. Expertise within a practice decreases the need for referral outside and the resulting loss of continuity.”<sup>173</sup>

The commentator neglected to mention that this sort of collaboration also increases practice revenues by keeping business within the group, decreases competition from midwives by allowing for the coordination and allocation of practice areas, and increases the possibility for physician oversight and control of midwives’ practice. Recent data also suggests that it is decoupling CNMs’ childbirth philosophy from their practice by bringing CNMs’ practices more in line with those of physicians. As noted above, most CNMs are employed by hospitals or as part of a physician practice.<sup>174</sup> Recent data shows that almost all CNM-attended births took place in hospitals.<sup>175</sup> Moreover, CNMs are regularly performing more

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<sup>171</sup> The joint statement has since been revised a third time, in 2000. Language strongly supporting collaboration between obstetricians and CNMs remains. It also notes that “statutory language requiring [physician] supervision” of CNMs and certified midwives (direct-entry midwives who have been certified by the American College of Nurse-Midwifery) is not “necessarily implied” by the statement’s avocation of collaborative practice. American College of Nurse-Midwives, *Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives* (Oct. 1, 2002), at <http://www.acnm.org/prof/display.cfm?id=121>.

<sup>172</sup> Hal C. Lawrence, *Not Either/Or, but Obstetricians and Midwives Together*, 112 PUB. HEALTH REP. 395 (1997).

<sup>173</sup> *Id.*

<sup>174</sup> See *supra*, note 53 and accompanying text.

<sup>175</sup> See Martin, *supra* note 16, at 14, 71 (listing statistics that 97 percent of CNM assisted births were in hospitals).

interventions. Their rates for some interventions such as EFM and labor induction – both interventions that commonly lead to a cascade of further interventions – presently approach or even equal those of physicians.<sup>176</sup> These data suggest that CNMs may have paid a high price for their legal recognition in all 50 states.

### B. Regulation of Direct-Entry Midwives

In contrast to regulations concerning CNMs, not all states permit DEMs to practice, and those that do differ in the type and scope of regulation they use. Eighteen states license, register or otherwise certify DEMs. Eleven allow DEMs to practice by judicial or statutory interpretation, without further regulation or oversight. Six have left the legal status of DEMs wholly undetermined. Another six ostensibly permit direct-entry midwifery, but either do not issue any licenses or permits, or otherwise make licensure requirements so arduous that few, if any, DEMs can actually practice. The remaining nine states, plus the District of Columbia, do not permit the practice of direct-entry midwifery.

Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Louisiana, Minnesota, Montana, New Hampshire, New Mexico, Oregon, South Carolina, Tennessee, Texas, Vermont and Washington license, register or otherwise certify DEMs.<sup>177</sup> Out of all of these, it appears that only one requires physician supervision of the DEMs' actions in normal childbirth: California.<sup>178</sup> The language tracks that in the state's supervision requirements for nurse-midwives. The supervising physician must be licensed and must currently practice or have current training in obstetrics.<sup>179</sup> While the physician need not be physically present while the midwife works,<sup>180</sup> he must have "reasonable geographic and/or temporal proximity" to the patient, so he could accept her care in case of an emergency.<sup>181</sup>

California's regulations are highly problematic for DEMs. The majority of births attended by DEMs take place at home.<sup>182</sup> Even if a

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<sup>176</sup> See *supra*, section III.

<sup>177</sup> Midwife Alliance of North America, *Direct-Entry Midwifery State-by-State Legal Status* (May 22, 2002), at <http://www.mana.org/stcharthtm.html> [hereinafter MANA]. MANA regularly maintains and updates the list.

<sup>178</sup> CAL. BUS. & PROF. CODE § 2507 (2002). New York also has a similar requirement, but because it effectively does not permit the licensure of direct-entry midwives, it is not included here. See *infra*, notes 203-04 and accompanying text.

<sup>179</sup> *Id.* at § 2507(b).

<sup>180</sup> *Id.* at § 2507(c).

<sup>181</sup> CAL. CODE REG. tit. 16 § 1379.22 (2002).

<sup>182</sup> See Martin, *supra* note 16, at 14, 71 (listing statistics that 57 percent of

DEM wished to practice at a hospital, it is unlikely that she would be able to obtain privileges to practice there, given her likely lack of an institution-based scholarly medical education and hostility and prejudice against direct-entry midwifery in the mainstream medical community.<sup>183</sup> Yet finding a physician who would agree to supervise a midwife who attends home births is very difficult. Many physicians are strongly opposed to home births. Dr. Vivian Dickerson, then a chairperson of one of ACOG's divisions, noted with respect to California's regulations that ACOG "'held out for a guarantee of supervision rather than a more collegial relationship, which was, we felt, an invitation to home births,'" and that "'ACOG has been strongly opposed to home births for more than a dozen years.'"<sup>184</sup> And even if a midwife can find a physician who is not philosophically opposed to home births, the physician may still not be able to supervise her if she performs home births, as his malpractice insurance carrier may prohibit it.<sup>185</sup> Problems with finding a physician supervisor became so great that, in 2000, an administrative law judge refused to discipline a DEM who was practicing without supervision, as he found that, despite her best efforts, no physician would agree to enter such a relationship with her.<sup>186</sup>

As noted above, California is unusual in requiring physician supervision of DEMs. It does not appear that any other state that licenses or certifies DEMs mandates a direct supervisory relationship with a particular physician. Instead, DEMs are often required to have a written plan for transferring clients to the care of a physician in case of a complication or emergency.<sup>187</sup> Other states are more restrictive,

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DEM-assisted births were in residences).

<sup>183</sup> See, e.g., SULLIVAN & WEITZ, *supra* note 26, at 135-42 (detailing the results of a statewide 1984 Arizona survey showing various aspects of physicians hostility towards midwives). See also *Nurse Midwifery Assoc. v. Hibbett*, 918 F.2d 605 (6<sup>th</sup> Cir. 1990) (discussing a possible conspiracy against midwives by doctors); *Sweeny v. Athens Reg'l Med. Center*, 709 F. Supp. 1563 (1989) for examples of antitrust suits brought by midwives against hospitals and physicians.

<sup>184</sup> ACDM, *supra* note 167 (emphasis omitted). See also Don Thompson, *Midwives Give Birth to Dispute Over Law*, VENTURA CTY STAR A4 (April 23, 2000) (noting that "Dr. Steven Polansky, a board member of the California Association of Obstetricians and Gynecologists Inc., says CNMs should practice only in hospitals, and lay midwives should not be allowed to practice at all. Like many doctors, he maintains it is inherently safer for children to be born in hospitals with instant access to emergency care if something goes wrong").

<sup>185</sup> See ACDM, *supra* note 167 (quoting Dr. Milton Estees who noted that "[c]ertain malpractice carriers won't insure anyone who has anything to do with home births").

<sup>186</sup> See Thompson, *supra* note 184.

<sup>187</sup> See, e.g., VT. STAT. ANN. tit. 26, § 4190 (Supp. 2002) (including CNMs as

requiring DEMs to consult with a physician regarding transfer in numerous specific instances.<sup>188</sup> Some require consultation in case of “significant deviations from normal” or in case of emergencies,<sup>189</sup> whereas others require midwives to refrain altogether from accepting the care of a woman who merely “exhibits signs or symptoms of increased risk” of complications.<sup>190</sup> This leads to the perhaps anomalous result that CNMs, who often have more formal training than many DEMs, cannot legally practice without some form of physician oversight, whereas licensed or certified DEMs may do so in their state(s) of licensure or certification.

A number of other states – Idaho, Kansas, Maine, Massachusetts, Michigan, Mississippi, Nevada, North Dakota, Oklahoma, Pennsylvania and Utah – either allow DEMs to practice by judicial or statutory interpretation.<sup>191</sup> Such states give DEMs legal sanction to practice, but do not otherwise regulate them. On the one hand, DEMs in these states need not fear that, by assisting in a normal birth without using any drugs or interventions,<sup>192</sup> they risk prosecution for the unlicensed practice of medicine or nursing (as they must fear in states in which their status has never been determined or in which direct-entry midwifery is expressly illegal). On the other hand, however, their scope of practice is effectively undefined, leaving them potentially open to charges of unlawfully practicing medicine if they use pitocin or another controlled substance to staunch a postpartum hemorrhage, or if they must cut an emergency episiotomy or make another emergent intervention before getting a woman or infant to a hospital.<sup>193</sup> Moreover, the same anomalies exist between the status of CNMs and DEMs as do in most states that license or certify DEMs. Thus, for example, a certified nurse-midwife in Massachusetts is subject to a number of regulations, including the requirement that she must function “as part of a health-care team which includes a qualified physician.”<sup>194</sup> A DEM in that state, on the other hand, is her

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well); S.C. CODE REGS. § 24(G)(5) (2001) (requiring written consent to treatment and treatment plan by midwife).

<sup>188</sup> See, e.g., S.C. CODE REGS. § 24(G)(1), (5) (2001) (requiring two visits with a physician and a backup emergency transfer plan). See also ARIZ. ADMIN. CODE R9-16-109 (2002) (listing various situations involving mother or newborn where medical consultation is required).

<sup>189</sup> N.H. REV. STAT. ANN. § 326-D:2 (Supp. 2002).

<sup>190</sup> COLO. REV. STAT. § 12-37-105 (2001).

<sup>191</sup> *Id.*

<sup>192</sup> Other than cutting the umbilical cord, of course.

<sup>193</sup> CNMs, on the other hand, are authorized to write and dispense certain prescriptions. See MASS. GEN. LAWS ch. 112, § 80E (2001).

<sup>194</sup> MASS. GEN. LAWS ch. 112, § 80C (2001).



own mistress . . . again, with the significant proviso that, should she need to intervene in a birth in order to avert disaster, she may be subject to prosecution.<sup>195</sup>

Connecticut, Nebraska, Ohio, South Dakota, West Virginia and Wisconsin neither regulate nor prohibit direct-entry midwifery, thereby leaving its legal status undetermined.<sup>196</sup> Midwives in these jurisdictions are in a similar position to their peers in Massachusetts, Kansas and other states which permit direct-entry midwifery by judicial or statutory interpretation. However, their situations are further complicated and made more tenuous by the constant fear that they may be prosecuted at any time for the unlicensed practice of medicine or nursing, with an uncertain outcome. On the one hand, the court may issue a ruling that midwifery is not the practice of medicine or nursing (as happened in Massachusetts and Kansas, for example). On the other, it may find them guilty of the unlawful practice of medicine or nursing. In either event, the decision will likely be appealed, therefore ensuring a long, uncertain, and likely costly interaction with the court system.<sup>197</sup>

A handful of states – Alabama, Georgia, Hawaii, New Jersey, New York and Rhode Island – allow direct-entry midwifery by statute, but make it practically impossible for DEMs to practice by failing to issue any licenses, or by making the requirements for licensure virtually identical to those for CNMs.<sup>198</sup> Finally, a minority of jurisdictions prohibit the practice of direct-entry midwifery: the District of Columbia, Illinois, Indiana, Iowa, Kentucky, Maryland, Missouri, North Carolina, Virginia and Wyoming.<sup>199</sup> In all these states, people who wish to practice direct-entry midwifery and women who wish to give birth at home or in an otherwise non-medical environment are forced to do so clandestinely, if they are able to do so at all.<sup>200</sup>

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<sup>195</sup> The Massachusetts Midwives Alliance and Massachusetts Friends of Midwives are presently seeking the enactment of legislation which would normalize the status of DEMs and allow for their licensure. Archie Brodsky, *Legislation Then and Now*, THE MFOM REPORT (Winter 2001), at <http://www.mfom.org/news.html> (last visited Feb. 18, 2003).

<sup>196</sup> MANA, *supra* note 177.

<sup>197</sup> Note that Ohio's legislature is presently considering a bill which would legalize and regulate direct entry midwifery. H.B. 477, 124<sup>th</sup> Gen. Assem., Reg. Sess.(Oh. 2001-2002).

<sup>198</sup> MANA, *supra* note 177.

<sup>199</sup> *Id.*

<sup>200</sup> Home births do take place in these states with DEMs in attendance, of course. It is merely that one does not often hear about it until a midwife is prosecuted. See Susan Kuczka, *High Court to Hear Midwife's Appeal*, CHI. TRIB.,

One would think that these states would not prohibit direct-entry midwifery if they rationally and thoroughly considered the scientific and sociological data comparing midwifery and obstetrics. Nevertheless, it appears that such consideration has not likely taken place in the states that prohibit direct-entry midwifery in fact or in practice. A recent case in which a DEM challenged laws restricting or prohibiting the practice of her profession on constitutional grounds in New York is instructive in this regard.<sup>201</sup> In *Lange-Kessler v. Dep't of Education of N.Y.*, the plaintiff midwife argued "that the PMPA [Professional Midwifery Practice Act] . . . deprived her of the ability to earn a living in her chosen profession, in violation of the Fourteenth Amendment to the United States Constitution, by effectively 'preclud[ing] the legal practice by direct entry midwives in the State of New York.'"<sup>202</sup> The PMPA requires all applicants for a license to practice midwifery either to hold a bachelor's degree in nursing plus additional midwifery training, or to have completed a program or training which the Department of Education determines is equivalent to the former.<sup>203</sup> All midwives licensed under the PMPA must also have a written practice agreement with a physician who practices obstetrics or with a hospital.<sup>204</sup> Lange-Kessler, a plaintiff, had no degree in nursing or midwifery, but instead – as is the case with many or most DEMs – was trained through apprenticeship.<sup>205</sup>

As the right to practice one's chosen profession is a property interest protected by the Fifth and Fourteenth Amendments to the Constitution, a statute restricting this interest must bear a rational relation to the legislature's stated objective in enacting the legislation.<sup>206</sup> To be constitutional under the most minimum standard of rationality review, "the legislation must: (1) advance legitimate governmental interests; (2) be rationally related to advancing those interests, and (3) not impose irrational burdens on individuals."<sup>207</sup> In

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June 5, 2002, at B5 (discussing the case of a midwife charged with manslaughter in the death of a baby she delivered at the child's parent's home). See also *Midwife, Aide Plead Guilty*, WASH. POST, May 6, 2000, at B2 (discussing the conviction of a midwife and her assistant for the death of a woman whose baby the pair delivered).

<sup>201</sup> *Lange-Kessler v. Dep't of Education of N.Y.*, 109 F.3d 137, 139 (1997). For an additional recent case considering a similar issue (with a similar outcome), see e.g., *Sammon v. N.J. Bd. of Med. Exam'rs*, 66 F.3d 639 (3d Cir. 1995).

<sup>202</sup> *Lange-Kessler*, 109 F.3d at 139 (quoting Plaintiff's Complaint).

<sup>203</sup> *Id.*

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

<sup>206</sup> *Id.* at 40 (citing *Schwartz v. Board of Bar Exam'rs*, 353 U.S. 232, 239 (1957); *Williamson v. Lee Optical Co.*, 348 U.S. 483, 490-91 (1955)).

<sup>207</sup> R. Randall Kelso, *Standards of Review Under the Equal Protection Clause*

this case, the court applied a minimum rationality standard. It held that it is incumbent on the plaintiff to show that “the legislative facts upon which the [statute] is apparently based could not reasonably be conceived to be true by the governmental decision-maker.”<sup>208</sup> Here, in other words, the court would strike down the statute as unconstitutional only if the plaintiff could prove that “there is no conceivable legitimate interest to support the statute, or that the statute’s means to advance the governmental ends are clearly irrational.”<sup>209</sup>

Using this test, the court proceeded to make short work of Lange-Kessler’s argument. It noted that state had a legitimate interest in protecting the health and welfare of pregnant women and children.<sup>210</sup> Given the existence of this interest, it then posed the following test: might the legislature have thought “that an applicant with (1) a formal education and (2) a written practice agreement with a licensed physician or hospital is more fit to practice midwifery than is an applicant without these qualifications?” Virtually without any apparent consideration of testimony offered by Lange-Kessler, it noted that the defendant offered an affidavit from a physician expert describing numerous complications which one may encounter in childbirth. The physician expert “assert[ed] that direct-entry midwives are not qualified to handle these complications.”<sup>211</sup> She also thought that DEMs exhibit “poor judgment” in home births.<sup>212</sup>

The court found this assertion compelling. Solely on the basis of the undisputed fact that some pregnant women may encounter complications and the unsupported opinion from one physician that midwives are incapable of handling such complications (even if only by promptly referring them to a physician), the court upheld the challenged statute.<sup>213</sup> The court acknowledged the plaintiff’s testimony only by way of stating that the mere existence of a dispute existed between the plaintiff and defendant “demonstrates the futility

*and Related Constitutional Doctrines Protecting Individual Rights: The “Base Plus Six” Model and Modern Supreme Court Practice*, 4 U. PA. J. CONST. L. 225, 230 (2002).

<sup>208</sup> Lange-Kessler, 109 F.3d at 140 (quoting *Vance v. Bradley*, 440 U.S. 93, 111 (1979)).

<sup>209</sup> Kelso, *supra* note 207, at 230.

<sup>210</sup> Lange-Kessler, 109 F.3d at 140 (citing *Roe v. Wade*, 410 U.S. 113, 162-63 (1973)).

<sup>211</sup> *Id.*

<sup>212</sup> *Id.* at 141.

<sup>213</sup> *Id.* (“In light of these risks, the legislature could reasonably have believed that midwives who have completed a nursing program, and who are affiliated with a medical professional, are more fit than direct-entry midwives to practice midwifery”).

of appellants' constitutional challenge: If reasonable minds could differ on the issue of a direct-entry midwife's competence, then it is wholly conceivable that the legislature took the view that direct-entry midwives are not likely to be sufficiently competent."<sup>214</sup>

If *reasonable* minds could differ, the court wrote, "Why did the court think the physician's beliefs concerning midwives were "reasonable?" Merely because one is an obstetrician does not automatically make one qualified to speak about the abilities of one's potential competitors, particularly competitors who use practices with which one is not familiar, and against whom one's profession has had a longstanding animus and rivalry."<sup>215</sup> It is surely reasonable to think that a practicing obstetrician should be able to testify as an expert concerning the complications that might be experienced in childbirth. On the other hand, it is not reasonable to think, in the absence of further information, that an obstetrician's opinion about the ability of a potential competitor to attend a birth or to identify and either manage or properly refer complications to a physician should be equally credible, particularly given the long history of obstetrical prejudice against midwifery.<sup>216</sup> Courts normally do not decide cases based solely on the opinion of one side or the other, absent supporting facts and, in cases such as this, empirical data. Otherwise, a court case had might as well be a popularity contest, for all the justice that would be rendered as a result. The court's task was not to acknowledge the existence of a dispute and therefore rule for the defendant as a result; instead, the court was to consider whether there was any rational basis for the legislature's enactment of the PMPA. In order to do this, it was incumbent on the court not merely to rely on the unsupported opinions of the parties in question or even the unsupported opinions of their experts. Rather, it needed also to examine the empirical evidence behind the opinions.

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<sup>214</sup> *Id.*

<sup>215</sup> See, e.g., LITOFF, *supra* note 67, at 3-26 (demonstrating the long rivalry between obstetricians and midwives). Litoff notes that, while the midwife debate of which she speaks took place in the first part of the 20<sup>th</sup> century, many of the attitudes embodied in it have remained at least up until recent years. She quotes Dr. Russell J. Paalman's 1975 presidential address to the annual meeting of the Central division of ACOG: "Can a nurse-midwife pick up all the early signs of impending disaster and consult an obstetrician in time? Is not every pregnant woman entitled to a trained obstetrician's care and delivery in a modern obstetric suite? . . . Except in a very few deprived areas, is there a place for nurse-midwives in the United States? I think not!" *Id.* at 15.

<sup>216</sup> See *supra*, notes 69-74 and accompanying text, concerning historical prejudice against midwives.

## V. THE CONTINUING ROAD TO LEGALIZATION OF DIRECT-ENTRY MIDWIFERY

Is it rational for a court to accord an otherwise unsupported expert obstetrician's opinion testimony more weight than published scientific evidence offered by a plaintiff midwife? We confer status on individuals and give weight to their speech in part based on characteristics such as their gender, age, education, employment and experience.<sup>217</sup> If relevant characteristics identify an individual as a likely knowledgeable proponent of a dominant, widely-accepted paradigm, the individual's word is generally accorded much more significance than that of an "outsider," one whose personal characteristics, experience and/or perspectives do not accord with the dominant paradigm in question or do not take their foundation from it.<sup>218</sup> Physicians may constitute one of the greatest exemplars of this. Paul Starr notes that "[i]n America, no one group has held so dominant a position . . . as has the medical profession."<sup>219</sup>

Power, at the most rudimentary personal level, originates in dependence, and the power of the professions primarily originates in dependence upon their knowledge and competence. Indeed, what makes dependence on the professions so distinctive today is that their interpretations often govern our understanding of the world and our own experience. To most of us, this power seems legitimate: When professionals claim to be authoritative about the nature of reality, whether it is the structure of the atom, the ego, or the universe, we generally defer to their judgment.<sup>220</sup>

This power does not merely extend to matters strictly within physicians' bona fide expertise. Rather, it goes beyond its foundation in the trust which the sick and their loved ones place in physicians and "spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant and often incompletely equipped."<sup>221</sup>

This deference is likely responsible for the continued outlaw status of DEMs in a significant minority of states, many prosecutions and licensure actions, and case outcomes such as that in *Lange-Kessler v. Dep't of Education of N.Y.* The American College of

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<sup>217</sup> See, e.g., LAY, *supra* note 8, at 25 (describing how status is afforded).

<sup>218</sup> Cf. LAY, *supra* note 8, at 78 (explaining the basis for one challenge midwives face).

<sup>219</sup> PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 4 (1982).

<sup>220</sup> *Id.*

<sup>221</sup> *Id.* at 5

Obstetricians and Gynecologists' opposition to direct-entry midwives and home births is both public and well known.<sup>222</sup> ACOG has lobbied state legislatures considering legalizing direct-entry midwifery to enact requirements intended to prevent planned, assisted home births from taking place.<sup>223</sup> At least one major health insurer cites ACOG's position on home births as the primary reason it refuses to cover home birth services unless mandated to do so by law.<sup>224</sup> Also, many criminal and administrative actions against midwives are initiated by complaints from physicians and hospitals who treat women and infants for complications following home deliveries attended by midwives, often although the mother has no complaint whatsoever about her care.<sup>225</sup> The recent prosecution of Frieda Miller in Ohio is

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<sup>222</sup> ACOG officially notes on its website that "[l]abor and delivery, while a physiologic process, clearly presents potential hazards to both mother and fetus before and after birth. These hazards require standards of safety that are provided in the hospital setting and cannot be matched in the home situation. ACOG supports those actions that improve the experience of the family while continuing to provide the mother and her infant with accepted standards of safety available only in hospitals that meet the standards outlined by the American Academy of Pediatrics and The American College of Obstetricians and Gynecologists." *ACOG News Release: December 12, 2001*, at [http://www.acog.org/from\\_home/publications/press\\_releases/nr12-12-01-4.cfm](http://www.acog.org/from_home/publications/press_releases/nr12-12-01-4.cfm) (last visited Feb. 9, 2003).

<sup>223</sup> ACDM, *supra* note 167.

<sup>224</sup> In support of its denial of coverage for home births, Aetna states that "[a]ccording to the policy statement on home delivery of the American College of Obstetricians and Gynecologists, labor and delivery, while a physiological process, clearly presents hazards to both the mother and fetus before and after birth. These hazards require standards of safety which are provided in the hospital setting and cannot be matched in the home situation. The Guidelines for Perinatal Care published by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists state that the hospital, including a birthing center within the hospital complex, provides the safest setting for labor, delivery, and the postpartum period. The use of other settings is not encouraged. Further, any facility providing obstetrical care should have the services listed as essential components for a level I hospital. This includes the availability of blood and fresh-frozen plasma for transfusion; anesthesia, radiology, ultrasound, electronic fetal heart rate monitoring and laboratory services available on a 24-hour basis; resuscitation and stabilization of all inborn neonates; nursery; and other services that are not available in the home setting." *Aetna Coverage Policy Bulletins: Number 0329 - Home Birth*, at <http://www.aetna.com/cpb/data/PrtCPBA0329.html> (last visited Feb. 9, 2003).

<sup>225</sup> For examples in one state that has seen a rash of such cases, see, e.g., *People v. Odum*, 69 Cal. Rptr. 2d 184 (Cal. App. 4<sup>th</sup> 1999) (holding that the unlicensed practice of midwifery is an unauthorized practice of medicine); *Northrup v. Superior Ct. of Modoc County*, 192 Cal. App. 3d 276 (1987) (holding that women could practice midwifery in these cases due to a religious exception). See also *Ex-Midwife Pleads Guilty in Baby's Death*, L.A. TIMES, May 20, 2000, at B5 (midwife admitted to inducing labor by administering medication without a doctor's supervision after stillborn baby brought to hospital); Virginia Ellis, *Bill Legalizing*

exemplary. Ms. Miller, a midwife with 17 years of experience in an estimated 2,000 births, was prosecuted and ultimately pled guilty for the unlicensed practice of medicine.<sup>226</sup> Ms. Miller gave pitocin, a prescription drug, to a client to staunch bleeding which continued for over an hour following childbirth at home.<sup>227</sup> Ohio law does not authorize DEMs to administer pitocin or any other drug during labor and delivery; direct-entry midwifery is unregulated in Ohio.<sup>228</sup> The client, who ultimately had to be transferred to the hospital for minor surgery to stop the bleeding, had no complaints about Ms. Miller's work, and both she and her baby were healthy and unharmed.<sup>229</sup> The physician who treated the client for the bleeding, however, took a different view of the matter when he learned of Ms. Miller's unauthorized use of pitocin.<sup>230</sup> He claimed he was obliged to report Ms. Miller's admission that she had used the drug to the county sheriff's office.<sup>231</sup>

A commentator on a midwifery discussion board concerning Ms. Miller's case made the following observation:

What if a midwife were to try to bring up charges against a hospital over hospital related circumstances at a hospital birth? Would a lawyer give her the time of day? Does the State take up action against Doctors who have a record of real patient abuse, and serve them multiple "cease and desist" orders? (Yeah, Right!)

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*Lay Midwifery Awaits Signing*, L.A. TIMES, Sept. 15, 1993, at A1 (describing the current legal problems facing midwives and the bill that could help them practice legally); Robin Greene, *Charges Filed Against Birthing Clinic Staffers*, L.A. TIMES, Mar. 13, 1993, at J1 (discussing the charges brought against several California women who were acting as lay midwives).

<sup>226</sup> John Horton, *Midwife's Use of Drugs is Focus of Court Case*, THE PLAIN DEALER, Mar. 11, 2002, at A1; John Horton, *Midwife Admits She Was Wrong to Administer Prescription Drugs*, THE PLAIN DEALER, May 2, 2002, at B1 (noting the new fervor to prosecute even midwives of long standing in the community).

<sup>227</sup> Horton, *supra* note 226.

<sup>228</sup> See *supra*, notes 196-97 and accompanying text.

<sup>229</sup> See Horton, *supra* note 226.

<sup>230</sup> *Id.* Ms. Miller's prosecution took place as the Ohio legislature considered a bill which would allow Ohio DEMs to choose whether or not to be licensed. John Horton, *Bill to Assist Ohio Midwives Attracts Critics*, THE PLAIN DEALER (Cleveland), Mar. 17, 2002, at B2. The state medical board is adamantly opposed to the licensure of DEMs unless they meet the same training as CNMs. See *id.* (stating that the state medical board feared a "dangerous blurring of the line between lay midwives and medical professionals").

<sup>231</sup> See Horton, *supra* note 226.

We all know that this would never happen. How is it that our legal system allows midwives to be prosecuted under the same questionable means? How is this legal?

... How is it that others don't see how completely wrong this "legal" process is and speak out about it?<sup>232</sup>

There is likely some truth to this commentator's statement. To take the Miller case as an example, it is difficult to imagine that the Holmes County sheriff's office would have taken the complaint sufficiently seriously to investigate and press charges had Ms. Miller been the complainant and the physician the object of the complaint. Ms. Miller's status as a direct-entry midwife would not add any weight to a complaint she might hypothetically have about the physician's care of her client. Rather, it might even work against it, depending on how much or little legitimacy her status as a DEM is given.<sup>233</sup>

Yet with increased status often comes increased normalization. Witness the case of CNMs. CNMs have successfully gained increased legitimacy in the mainstream over the past two decades. Not only are they allowed to practice in all fifty states, but they also receive reimbursement from federal health programs and some private insurers for their services,<sup>234</sup> are permitted in many states to administer medications,<sup>235</sup> and may even enjoy hospital privileges in some areas. Yet they may not legally practice in some states without physician supervision, and must collaborate with physicians in the remaining states.<sup>236</sup> Moreover, their intervention rates have been steadily rising. Many now approach those of physicians.<sup>237</sup> Many CNMs further feel obliged to continue to work with and potentially cede ground to physicians in order to perpetuate and further cement their entry into the mainstream of obstetrical practice.<sup>238</sup>

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<sup>232</sup> Posting by Zoie (May 7, 2002, 21:03:18), at [http://www.midwiferytoday.com/forums/topic.asp?TOPIC\\_ID=2092](http://www.midwiferytoday.com/forums/topic.asp?TOPIC_ID=2092).

<sup>233</sup> See, e.g., LAY, *supra* note 8, at 78 (explaining one way in which status is afforded).

<sup>234</sup> *Contra*, 42 U.S.C. § 1395k(a)(2)(B)(iii) (2000) (explaining that services are excluded under statute).

<sup>235</sup> See, e.g., CALIF. BUS. & PROF. CODE § 2746.51(a) (2001) (allowing midwives to administer drugs when certain requirements and conditions are met); N.Y. EDUC. LAW § 6951 (McKinney 2001).

<sup>236</sup> See *supra*, section IV.

<sup>237</sup> See, e.g., *supra*, notes 140 and 154 and accompanying text.

<sup>238</sup> See, e.g., Mary Ann Shaw, *The Best of Both Worlds*, 32 QUICKENING 3, 3 (Sept./Oct. 2001), available at <http://www.acnm.org/prof/display.cfm?id=256> (last visited Aug. 3, 2001) (Ms. Shaw, the president of ACNM, noted in connection with the 2000 Joint Statement between ACOG and ACNM: "To those who might feel that



If mainstream respect for one's knowledge and opinion derives at least in part from one's position as a stakeholder or expert within a dominant paradigm, not all DEMs are interested in attaining it. As noted earlier, some DEMs eschew regulation even in those states in which direct-entry midwifery is legal and its practice is regulated. Freedom to practice as they wish and fear of co-optation are frequently cited. One midwife interviewed in Deborah Sullivan and Rose Weitz's 1988 study of direct-entry midwives commented in opposition to licensure that "I'm quite sure, unfortunately, that there may be some midwives out there who are willing to do things that I would never do at home . . . [but] I don't want a mass organization where I have to answer to somebody."<sup>239</sup> DEMs also cite concerns about consolidating knowledge in the hands of the profession at the expense of laypeople, thereby contravening a philosophical tenet of midwifery that knowledge is to be shared in order to promote the responsibility of the pregnant woman for her own care and lessen the hierarchical relation between midwife and client. One unlicensed midwife observed that "all professions are a conspiracy against the laity," and that "licensing has always existed . . . to protect the interests of the practitioners, not the consumers."<sup>240</sup>

Yet these DEMs appear to represent a minority. Legalization of direct-entry midwifery through regulation brings too many benefits to be dismissed save by a few holdouts. Regulation ensures that all midwives have met certain minimum criteria concerning education, training and practice, and gives an official imprimatur to one's practice.<sup>241</sup> As such, it adds to a midwife's reputation, and offers her a certain degree of legitimacy which she might not otherwise have. It further helps protect potential clients from dangerous or unqualified practitioners. Regulation, at least in those states that neither expressly prohibit nor permit direct-entry midwifery, would also allow DEMs to practice openly, without fear of prosecution for merely doing their

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the revised Joint Statement does not go far enough, I must point out that our ACOG colleagues are to be applauded for their willingness to publicly endorse midwifery at a time when the healthcare climate is becoming more competitive and, in some places, downright hostile to non-physician providers. It would behoove us all, therefore, to recognize that not only must we work collaboratively with physicians in order to provide optimal care to women and their families, but we need to acknowledge that MD support is essential to future legislative gains, for greater access to hospital privileges and HMO panels, for increased third party reimbursement, and for keeping malpractice insurance options open").

<sup>239</sup> SULLIVAN & WEITZ, *supra* note 26, at 99.

<sup>240</sup> *Id.* at 99-100.

<sup>241</sup> *See, e.g., id.* at 98-99 (discussing the benefits of licensing for midwives).

*See also* LAY, *supra* note 8, at 2-3 (explaining benefits of legalizing midwifery).

job.<sup>242</sup> In any state, it may also lead the way for increased acceptance by physicians and hospitals to serve as backup, improved malpractice insurance coverage, legal permission to use certain drugs and procedures in childbirth, and insurance payment for services.<sup>243</sup> While it entails that midwives submit to certain formal requirements and practice within the state's restrictions, it also appears that, at least to date, few states have taken significant action to erode DEMs' self-governance, for example by requiring physician supervision or by subjecting them to governance by a state board with a majority physician representation.<sup>244</sup>

Direct-entry midwifery clearly ought to be legal in all states, given data on the safety of normal births at home with trained DEMs. There also exist numerous good reasons for licensure of DEMs in all states, from the perspectives of both DEMs themselves and their potential clients. The call for legalization and regulation is not novel. Numerous law review articles have been written over the past fifteen years advocating the legalization of direct-entry midwifery and assisted home births.<sup>245</sup> Yet it appears that direct-entry midwifery will not be universally legalized until it becomes more mainstream. This does not mean, however, that direct-entry midwifery should seek to become assimilated into medical practice. Instead, more room must be made within the mainstream – or at least in the halls of state

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<sup>242</sup> See *id.* at 98 (discussing the credibility licensing provides to midwives by allowing them to practice openly); Horton, *supra* note 226.

<sup>243</sup> See SULLIVAN & WEITZ, *supra* note 26, at 98 (explaining midwives' hope of acceptance by members of the medical community).

<sup>244</sup> In most states that regulate DEMs, state oversight takes place through a special midwifery board, rather than through the medical board. See, e.g., N.H. REV. STAT. ANN. § 326-D:3 (2002) (establishing a midwifery council comprised of three midwives, one obstetrician, one pediatrician, and one member of the general public who is familiar with the practice of midwifery).

<sup>245</sup> See, e.g., Michael A. Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 J. FAM. L. 609, 621 (1997-1998) (noting the role of states in regulating parents' decisions to have children at home or in a medical setting); Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL'Y, POL. & L. 813 (1994) (noting the safety of midwifery and the concurrent hostile socio-political undercurrents preventing its acceptance); Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. AND FEMINISM 315 (1993) (arguing midwifery should not be regulated as strictly as other medical professions); Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909, 910-11 (1986) (proposing a model statute that supports and regulates home birth and lay midwives); Kathleen M. Whitby, Comment, *Choice in Childbirth: Parents, Lay Midwives, and Statutory Regulation*, 30 ST. LOUIS U.L.J. 985 (1986) (supporting people's right to choose to have a midwife).

legislatures – for alternate conceptions of how childbirth should take place.

This is not an insurmountable task, however long it may take to bring it about. At the same time that many obstetricians have attempted to consolidate their near-monopoly over the conceptualization and practice of pregnancy and childbirth in the United States, other groups have had at least some success in seeking to alter them. Witness, for example, the rise of “home-like” labor and delivery suites, the attendance of births by fathers and other family members, increased support for breastfeeding, and “rooming in,” where the mother keeps the baby with her in the hospital at all times, rather than transferring her infant to the newborn nursery. These changes came in response to some of the childbirth practices of the 1950’s, ‘60’s and ‘70’s.<sup>246</sup> While some would argue that developments such as these are merely small concessions on the part of doctors and hospitals in an attempt to retain their dominant position in childbirth, others observe that they would never have come about without agitation by groups who were unhappy with mainstream practices.<sup>247</sup>

Jana Sawicki observes that while birth technologies have led to further medical control of women’s bodies and desires with respect to conception, pregnancy and childbirth,

this control is not secured primarily through violence or coercion, but rather by producing new norms of motherhood . . . and by offering women specific kinds of solutions to problems they face. In fact, there may be better solutions; and there may be better ways of defining the problems. There is the danger that medical solutions will become the only ones and that other ways of defining them will be eclipsed.<sup>248</sup>

The birth technologies we see used in most births in the United States are not the result of coercing all pregnant women into hospital deliveries and a cascade of medical interventions. While some women may indeed feel forced into a hospital birth in order to obtain insurance coverage for the event or for other reasons, it must also be

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<sup>246</sup> See, e.g., YVONNE BRACKBILL ET AL., BIRTH TRAP 114-15 (1984) (discussing ways in which the consumer of maternity care can bring about changes in the system).

<sup>247</sup> See, e.g., JANA SAWICKI, DISCIPLINING FOUCAULT: FEMINISM, POWER, AND THE BODY 81-82 (1991) (describing mainstreaming natural methods).

<sup>248</sup> *Id.* at 85.

admitted that birth technologies fulfill genuine needs.<sup>249</sup> Childbirth is often perceived as a frightening, painful and arduous experience, fraught with potential danger for both mother and fetus. Most women legitimately want their births to be as safe and comfortable as they can reasonably expect. Physicians and stakeholders in birth technologies portray the panoply of equipment, analgesia and interventions that they offer as meeting these needs. This is unsurprising. It is wholly inappropriate, however, for physicians and others to go farther by putting forth the view that births accompanied by medical and technological interventions are moreover the safest and best means of delivery for all women, no matter what a woman's risk status and objectives might be. Too much evidence to the contrary has been amassed over the past two decades and more with respect to births involving healthy women and fetuses.

The fact that this research has been performed by mainstream scientists and researchers is likely the edge that DEMs, home birth parents, and other supporters of alternative childbirth methods need in order for their perspective to be heard, rationally considered, and ultimately accepted by legislators and the public. DEMs and their supporters already make ample use of the evidence supporting their methods.<sup>250</sup> To ultimately attain success, however, they must do more than merely cite statistics. Rather, they must show that they are the type of practitioner who can achieve such results consistently, and that, by legalizing their practice, women will be afforded additional safe options for childbirth, and will not be preyed upon by hordes of inept practitioners in the process. Towards this end, DEMs and their supporters need to determine what fears key legislative members have about direct-entry midwifery and home births, and seek to dispel them. As one lobbyist for a state direct-entry midwifery guild noted, "People may imagine herbs and candles . . . that's not so."<sup>251</sup> Equally importantly, DEMs must distinguish themselves from incompetent or untrained practitioners.<sup>252</sup> They must show that they, as midwives

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<sup>249</sup> See *id.* (noting hospital delivery has advantages).

<sup>250</sup> See, e.g., Legislative Recommendation on Direct-entry Midwifery in Ohio, available at [http://www.collegeofmidwives.org/legal\\_legislative01/ohio20Legreport98.htm](http://www.collegeofmidwives.org/legal_legislative01/ohio20Legreport98.htm) (Mar. 9, 1998) (presenting a summary of the testimony prepared by Anne Kinne to the Ohio Legislature on Direct-entry midwifery).

<sup>251</sup> LAY, *supra* note 8, at 81. Actually, it may indeed be so for some practitioners who are entirely experienced and competent, but is probably used in practice quite differently than how a hypothetical legislator might imagine. See, e.g., Midwifery Today Forums, Herbs and Natural Remedies, at [http://www.midwiferytoday.com/forums/forum.asp?FORUM\\_ID=58](http://www.midwiferytoday.com/forums/forum.asp?FORUM_ID=58) (last visited Feb. 18, 2002) (discussing herbal remedies recommended by midwives).

<sup>252</sup> See LAY, *supra* note 8, at 81-82 (describing tactics midwives could use to

certified by NARM or another organization, or who otherwise have a particular type of training and set of experiences, are responsible and skilled birth practitioners of the same sort who achieved the good home birth outcomes demonstrated in the studies they cite. While these efforts may not always be successful, they are the most likely means by which DEMs will ultimately achieve legal recognition throughout the United States.

## VI. CONCLUSION

The case in favor or against midwifery should hinge on scientific and sociological outcomes, rather than on prejudice or on excessive deference to one stakeholder at the expense of another. The question of midwifery can largely be decided by looking at decades worth of data supporting midwifery's safety, decreased morbidity and cost effectiveness in most pregnancies. The problem is that some courts and legislatures have viewed the matter not as one determinable by scientific study. Rather, it appears they have instead relied largely on the opinions of obstetricians who have long denigrated midwifery, notwithstanding the existence of significant scientific data upholding the safety and cost-effectiveness of midwifery as compared with obstetrics in normal births. Thus, we continue to see prosecutions of midwives for the unlicensed practice of medicine or nursing in states that prohibit direct-entry midwifery, and arguably harassing complaints by physicians or hospitals against midwives in states in which they may practice merely because something went wrong, whether or not there was any actual negligence on the midwife's part.<sup>253</sup>

Legislatures, courts and the public ought not unquestioningly to accept the dominant view that physician-attended hospital births characterized by interventions are the best and safest way for all women to give birth, notwithstanding their risk factors. Studies performed by mainstream physicians and scientists have demonstrated that home births attended by direct-entry midwives are also safe and effective, and have benefits such as lower intervention rates and cheaper costs. They also have less tangible benefits, such as increasing the psychological comfort of the pregnant woman by allowing her to remain in familiar surroundings, empowering the woman by allowing her to claim her own act of giving birth, and cementing bonds between family members by making the birth a

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attain legalization).

<sup>253</sup> See *supra*, notes 225-31 and accompanying text. See also Posting by Zoie, *supra* note 232 (explaining results of a challenges to midwifery).

communal experience. DEMs, home birth parents and their supporters need to continue their efforts to legalize direct-entry midwifery, as one excellent option among others for normal childbirth.

