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**LET WOMEN CHOOSE WHAT IS BEST FOR
THEIR BODIES AND BABIES: WHY
ILLINOIS SHOULD LEGALIZE
DIRECT-ENTRY MIDWIFERY**

Theresa Kleinhaus*

Throughout the world there exists a group of women who feel mightily drawn to giving care to women in childbirth. At the same time maternal and fiercely independent, responsive to the mother's needs yet accepting full responsibility as her attendant, such women are natural midwives. Without the presence and acceptance of the midwife, obstetrics becomes aggressive, technological, and inhuman. Today, this "natural midwife" is emerging from obscurity, making herself well-known to the people she serves and to the system she cannot work within, even where she must practice illegally.¹

* Theresa Kleinhaus is a lawyer practicing in Chicago, IL. She is a member of the Order of the Coif and is licensed to practice in the state of Illinois and the U.S. District Court for the Northern District of Illinois. Her research interests are constitutional litigation, international human rights law, and public interest law. Theresa graduated *magna cum laude* in December 2010 from DePaul University College of Law. She recently co-authored *Confronting the Past: the Elusive Search for Post-Conflict Justice*, which was published in THE IRISH JURIST in April 2011.

¹ CAROL LEONARD, *LADY'S HANDS, LION'S HEART: A MIDWIFE'S SAGA* 61 (2008) (quoting G.J. Kloosterman, professor of obstetrics and gynecology at the University of Amsterdam, Holland).

INTRODUCTION

In ten states, including Illinois, women do not have the freedom to choose a direct-entry midwife to assist in a home birth.² A direct-entry midwife is a person trained, and often professionally licensed, to help a woman give birth in the home.³ As this article will discuss, even though the evidence shows that birthing at home with a midwife is safe, comfortable, and the preference of many women, Illinois continues to prohibit direct-entry midwifery. The opposition to home birthing and midwifery is based on a historic prejudice against midwifery.⁴ The historically male-dominated field of obstetrics has feared midwifery as a competitor in the childbirth field, and has insisted that midwifery is unsafe.⁵ The American College of Obstetrics and Gynecology continues to assert that home births are more dangerous than hospital births,⁶ even though studies show this is not true.⁷ The goal of any legal regime governing childbirth should not be to have all births in hospitals or for all births to occur at home. Rather, the goal ought to be to allow each woman to choose for herself and her baby which child birthing option is best for her. This paper will examine the role of midwifery throughout his-

² *Direct-Entry Midwifery State-by-State Legal Status*, MIDWIVES ALLIANCE OF NORTH AMERICA, <http://mana.org/statechart.html> (last visited Feb. 10, 2012).

³ *Midwifery Definitions*, MIDWIVES ALLIANCE OF NORTH AMERICA, <http://mana.org/definitions.html#DEM> (last visited Feb. 10, 2012).

⁴ See Jason M. Storck, *A State of Uncertainty: Ohio's Deficient Scheme of Midwifery Regulation in Historical and National Context*, 8 QUINNIPIAC HEALTH L.J. 89, 92 (2004) (discussing the history of opposition to home birth).

⁵ *Id.* at 92–95.

⁶ *The American College of Obstetrics and Gynecology Issues Opinion on Planned Home Births* (Jan. 20, 2011), http://www.acog.org/About_ACOG/News_Room/News_Releases/2011/The_American_College_of_Obstetricians_and_Gynecologists_Issues_Opinion_on_Planned_Home_Births [hereinafter ACOG].

⁷ E.g., Kenneth C. Johnson & Betty-Anne Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1416 (June 18, 2005); A. Mark Durand, *The Safety of Home Birth: The Farm Study*, 82 AM. J. PUB. HEALTH 450, 452 (1992).

tory, the current data on its utility, Illinois' regulation of it, and how Illinois law on this issue can be improved.

II. BACKGROUND ON MIDWIFERY IN THE UNITED STATES

A. *The History of Midwifery in the United States*

The history of midwifery in the United States has included powerful lobbies for both hospital birthing and home birthing. Although home birthing is still somewhat rare, it has been gaining in popularity over the last quarter century.

1. Midwifery in Colonial Times

The colonial settlers in America brought the practice of midwifery with them from Europe.⁸ In colonial times, midwifery was a social event with friends, family, and midwives involved in the birth.⁹ Colonial midwives usually observed other midwives until they felt comfortable delivering babies themselves.¹⁰ Typically, physicians only performed very difficult births and often physicians and midwives worked together.¹¹

2. The Rise of Obstetrics

Midwifery came under threat from medical doctors at the end of the eighteenth century. The first doctor specializing in childbirth, William Shippen Jr., began to practice in 1763, and within ten years, the colonists had come to accept that male doctors delivered babies.¹² By the middle of the nineteenth century, doctors regularly specialized in childbirth and became birth at-

⁸ Storck, *supra* note 4, at 90.

⁹ *Id.* at 91. See also Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 *CARDZO WOMEN'S L.J.* 61, 63 (2004).

¹⁰ See Tovino, *supra* note 9.

¹¹ See *id.* at 63.

¹² See Storck, *supra* note 4, at 91–92.

tendants for middle and upper class families.¹³ Women were eager to make childbirth less traumatic, less painful, and less dangerous.¹⁴ Thus, women were willing to try technological advances that promised these results.

As doctors understood germ theory better, they began to believe that births would be safer at hospitals where doctors could control the level of sanitation.¹⁵ Doctors also needed patients on whom to practice their new birthing technology and skills, as well as patients with whom to teach medical students.¹⁶ The wave of immigrants that arrived in the United States in the late nineteenth century proved willing to be these “practice patients.”¹⁷ Yet within the wave of immigrants, there were also many midwives from countries where midwifery was still the dominant approach to childbirth.¹⁸ Thus, obstetricians felt their prestige and profit margins were endangered by the new immigrants’ midwifery practice.

Beginning with the 1911 publication of the study entitled *The Midwife Problem and Medical Education in the United States*, obstetricians began to paint a picture of midwives as backwards and unsafe, while doctors were described as professional and very safe.¹⁹ Presumably, these doctors were genuinely concerned about their patients’ well-being. However, the doctors were also concerned with their own economic well-being. For example, Dr. Joseph B. DeLee, an obstetrician from Chicago, advocated for the removal of all legal sanction of midwifery.²⁰ Dr. DeLee made speeches and wrote articles on the “dangers” of midwives and told his fellow obstetricians that the public must know that obstetrics is “a high art” that must be on the same pay scale as surgery.²¹ DeLee and others published arti-

¹³ See *id.* at 92.

¹⁴ See *id.*

¹⁵ See *id.* at 92–93.

¹⁶ See *id.* at 93.

¹⁷ See *id.*

¹⁸ See *id.*

¹⁹ See *id.*

²⁰ See *id.* at 94.

²¹ *Id.*

cles in women's magazines arguing for a more scientific and medical view of childbirth and promising that technological advances, such as "prophylactic forceps," were far superior to midwifery.²²

The powerful propaganda campaign led by Dr. DeLee, along with the growing inclination of many women to trust "scientific" approaches, contributed to the new cultural phenomenon of childbirth in hospitals attended by men, rather than the historical practice of childbirth in the home attended by female midwives.²³ By 1950, over 90% of white women gave birth in hospitals, and the numbers for African American women were increasing as well.²⁴

3. The Midwifery Movement in the Twentieth Century

The obstetrical revolution that imposed hospital birthing on women in the early part of the twentieth century met its counter-revolution in the latter part of that century. In the 1970s, many women in the United States began to voice their concerns that hospital birthing was male-dominated and that pregnant woman felt alone and powerless during hospital deliveries.²⁵ Activists began to critique the hospital birthing experience as one that unnecessarily regarded childbirth as a disease to be treated rather than a natural, normal family event.²⁶ Moreover, women with experience in the ongoing countercultural movements questioned white male supremacy in all fields, including obstetrics.²⁷

²² *Id.* at 94–95.

²³ *See id.* at 95.

²⁴ *Id.*

²⁵ *See id.* at 95–96.

²⁶ *See* Bruce Hoffman, *Minding the Gap: Legal Ideals and Strategic Action in State Legislative Hearings*, 33 *LAW & SOC. INQUIRY* 89, 94 (2008) (discussing his study of the efforts to legalize non-nurse midwifery).

²⁷ *See, e.g.,* Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 *LAW & SOC'Y REV.* 125, 131–32 (2005).

Inspiration from the feminist movement led some activists to call for a return to home births and non-nurse midwifery.²⁸ In the early 1970s, in rural Tennessee, a group of countercultural activists started "The Farm," a spiritual community that also engaged in the practice of midwifery.²⁹ Ina May Gaskin and other midwives at "The Farm" developed a system of care focused on maternal-child health services.³⁰ Gaskin wrote a popular book called *Spiritual Midwifery* in 1975 and became a spokeswoman for the movement.³¹ Meanwhile, groups focused on home birthing emerged in San Francisco and Seattle.³² None of these groups knew of each other; they developed independently due to a demand for home birthing options.³³

The obstetrics community responded aggressively to the rise of the home birthing movement. By 1971, doctors were already meeting to discuss the "midwifery problem."³⁴ Medical associations began pressuring legislatures to make midwifery illegal where it formerly was legal.³⁵ Midwives were largely undeterred by the pressure from physicians until states began prosecuting them for delivering healthy babies.³⁶ In response to this, midwives began seeking licensure.³⁷ Seeking state approval in the form of licensure contradicted the rebellious attitude of many midwives, but facing criminal prosecution was too high a price to pay.³⁸ Thus, midwives in some states began advocating for their legislatures to recognize their profession as a legitimate and safe alternative to medical childbirth.³⁹ Midwives today

²⁸ *See id.*

²⁹ *See id.* at 131–32.

³⁰ *See id.*

³¹ *Id.*

³² *See id.* at 133.

³³ *See id.* (discussing the development of alternative birthing communities in the 1970s).

³⁴ *See id.* at 133.

³⁵ *See id.* at 134.

³⁶ *See id.* at 134–35.

³⁷ *See id.* at 135.

³⁸ *See id.* at 135–36.

³⁹ *See id.*

continue advocating for home birth through such organizations as the Midwives Alliance of North America.⁴⁰

4. The Midwives Who Work Today

As a result of the efforts of the home birth and midwifery movement of the 1970s, midwives are now an active professional group with a strong sense of identity. The Midwives Alliance of North America prides itself on its own distinct model of assisting with childbirth. They define midwifery care as “uniquely nurturing, hands-on care before, during, and after birth.”⁴¹ These Midwives describes themselves as “health care professionals specializing in pregnancy and childbirth who develop a trusting relationship with their clients which results in confident, supported labor and birth.”⁴² They practice what they call the “Midwives Model of Care™.” This model is “based on the fact that pregnancy and birth are normal life events.”⁴³

The Midwives Model of Care includes: monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and post-partum support; minimizing technological interventions and; identifying and referring women who require obstetrical attention.⁴⁴

The application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section.⁴⁵

⁴⁰ See *What is MANA?*, MIDWIVES ALLIANCE OF NORTH AMERICA, <http://mana.org/about.html> (last visited Feb. 10, 2012).

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Midwifery Definitions*, *supra* note 3.

⁴⁴ *Id.*

⁴⁵ *Id.*

There are two basic types of midwives: direct-entry midwives, and certified nurse-midwives.⁴⁶ A direct-entry midwife is defined as “an independent practitioner educated in the discipline of midwifery” which is distinct from “the discipline of nursing.”⁴⁷ Direct-entry midwives may be professionally licensed.⁴⁸ When they are licensed, they are often referred to as “Certified Professional Midwives” (“CPM”).⁴⁹

A Certified Professional Midwife is defined as a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the midwifery model of care.⁵⁰ The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings.⁵¹

The NARM Certification credential is required for licensure in most of the states that license direct-entry midwives and in all of the states that license midwives specifically for out-of-hospital birth.⁵² CPMs “have demonstrated the knowledge and skills to provide full prenatal, birth, and postpartum care to low-risk women, to recognize deviations from normal [birth], and to refer, consult, or transfer care if appropriate.”⁵³ Thus, if a state

⁴⁶ *Id.* In three states, New York, New Jersey, and Rhode Island, a third category of midwives, the certified midwife, also exists. These midwives often have professional certifications in other health fields and have training equivalent to the Certified Nurse-Midwives. *See generally Our Credentials*, AMERICAN COLLEGE OF NURSE-MIDWIVES, <http://www.midwife.org/Our-Credentials> (last visited Feb. 10, 2012). Because legally they are virtually identical to Certified Nurse-Midwives, they are not discussed as a separate category in this article.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² North American Registry of Midwives, *Position Paper on the Practice of Midwifery* (Apr. 6, 2003), available at <http://www.narm.org/pdf/files/practiceofmidwifery.pdf>.

⁵³ *Id.*

chooses to regulate direct-entry midwives, NARM encourages the requirement of the CPM credential as the standard for eligibility.⁵⁴

“A Certified Nurse-Midwife (CNM) is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives.”⁵⁵ CNMs have a nursing degree plus further study in gynecology and obstetrics.⁵⁶ They usually work in hospitals or birth centers, rather than performing home births, due to state statutes and regulations.⁵⁷ A small number of CNMs, however, have been able to maintain a home birth practice.⁵⁸

The two types of midwives—direct-entry midwives and nurse-midwives—both have a system of training and credentialing that makes them reliable birth attendants. While the two groups have distinct professional identities, both groups have a long history of supporting women’s choices in childbirth.⁵⁹

B. Comparing Obstetrics and Midwifery: Safety, Lawsuits, and Patient Satisfaction

In addition to understanding the role of midwives today, it is also important to understand how the Midwifery Model of Care™ compares to the obstetrics model of care. In comparing data from obstetrical births in hospitals to data from home births, studies show that while obstetrics is necessary for high-risk births, home birth can be a comparably safe alternative for

⁵⁴ See *id.*

⁵⁵ *Midwifery Definitions*, *supra* note 3.

⁵⁶ Tovino, *supra* note 9, at 69.

⁵⁷ See *id.*

⁵⁸ For a discussion of a modern-day midwifery home practice, see generally CARA MUHLHAHN, *LABOR OF LOVE: A MIDWIFE’S MEMOIR* (2009).

⁵⁹ See generally, *Goals of MANA*, MIDWIVES ALLIANCE OF NORTH AMERICA, <http://www.mana.org/goal.html> (last visited Feb. 10, 2012) (providing a history and background on the group’s work toward promoting midwifery and home birth opportunities for women).

low-risk births.⁶⁰ Home birth is also less likely to lead to litigation and more likely to be a satisfactory experience for women.⁶¹ This section will examine the strengths and weaknesses of each model, the likelihood of litigation of each model, and the reasons that obstetricians still oppose home birth.

1. The Obstetrics Model

Obstetrics is the diagnosis and treatment of pathology, meaning complications or diseases during pregnancy.⁶² Since obstetricians view birth as inherently dangerous and complicated, most obstetricians consider no birth to be normal until it is over.⁶³ For example, obstetricians routinely undertake preemptive medical interventions, such as inserting an intravenous line or performing episiotomies (surgical cuts made to the vaginal wall to widen it in preparation for delivery) in all women who are going to deliver, rather than deciding based on whether it is a high- or low-risk birth.⁶⁴ These procedures stand in stark contrast to the midwifery model which views low-risk births as natural and normal.⁶⁵

Although obstetricians are very skilled at high-risk births, it was not their presence that decreased maternal and infant mortality in industrialized nations.⁶⁶ By comparing data over the past century from countries that predominately use midwives with data from countries that predominately use obstetricians, one can see that general medical advances, such as blood transfusions and antibiotics, have allowed women to avoid severe complications in high-risk pregnancies, not obstetricians.⁶⁷ For

⁶⁰ Johnson, *supra* note 7.

⁶¹ See *infra* notes 115–19 and accompanying text.

⁶² Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legalization*, 13 HEALTH MATRIX 325, 330 (2003).

⁶³ *Id.*

⁶⁴ See *id.* at 330–31.

⁶⁵ See Midwifery Definitions, *supra* note 3 (explaining the midwifery model of care).

⁶⁶ See Hermer, *supra* note 62, at 335–39.

⁶⁷ See *id.* at 337–39.

example, in the Netherlands, throughout the twentieth century, the majority of women used midwives for home births rather than hospitals.⁶⁸ Meanwhile, in the United States, most women increasingly used obstetricians as birth attendants.⁶⁹ Yet, both countries enjoyed a rapid decline in maternal and infant mortality rates.⁷⁰ It follows then that the cause of the decline was the medical advances rather than the birth attendant.⁷¹ Thus, obstetrics and midwifery can both be safe, modern ways of birthing.

While both models of birthing can be safe, obstetrical births pose the risk of unnecessary intervention. In some instances, because they view birth from a pathological perspective, obstetricians perform medical interventions in the process of childbirth where such intervention is not necessary.⁷² The biggest medical intervention associated with childbirth is the cesarean section. The rate of cesarean sections performed in the United States is not only increasing but is significantly higher than the rates of other countries.⁷³ Cesarean sections are performed in 32% of American births,⁷⁴ whereas the Dutch perform cesarean sections in around 13.5% of their births.⁷⁵ Meanwhile, the neonatal mortality rates in the United States are much higher than

⁶⁸ *Id.* at 337.

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *See id.* at 337–38.

⁷² *See id.* at 330–31.

⁷³ *Id.* at 342.

⁷⁴ Fay Menacker & Brady E. Hamilton, *Recent Trends in Cesarean Delivery in the United States*, NCHS Data Brief, No 35 (March 2010), available at <http://www.cdc.gov/nchs/data/databriefs/db35.pdf> (indicating that the cesarean rate rose by 53% from 1996 to 2007 in Illinois, and that 30% of babies are delivered via cesarean section).

⁷⁵ Luz Gibbons et al., *The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed Per Year: Overuse as a Barrier to Universal Coverage*, World Health Report 1, 25 (2010), <http://www.who.int/healthsystems/topics/financing/healthreport/30C-sectioncosts.pdf>.

those of other developed nations.⁷⁶ This indicates that too many unnecessary cesarean sections are being performed with an end result of higher risks to mothers and infants.⁷⁷ Cesarean sections can threaten fetuses by causing birth traumas and fractures.⁷⁸ Furthermore, the evidence indicates that increased numbers of cesarean sections do not actually reduce the number of birth injuries, even though such claims are frequently used to justify the procedure.⁷⁹ In addition to these risks, the rate of maternal mortality for cesarean sections is approximately two to six times higher than that of vaginal deliveries, with estimates of up to 200 maternal deaths annually as a result of unnecessary cesarean sections.⁸⁰

In addition to performing too many cesarean sections, obstetricians are also more likely to use an epidural, which is a form of anesthesia, than are midwives.⁸¹ Use of epidurals can increase the need for the stimulation of labor, episiotomies, and delivery with forceps, because the epidural decreases the strength of the contractions and the ability to “spontaneously expel” the fetus.⁸² Obstetricians are also more likely than midwives to use episiotomies.⁸³ Episiotomies can lead to infections.⁸⁴ In fact, infections from episiotomies account for 20% of

⁷⁶ See *Country Comparison: Infant Mortality Rate*, CIA WORLD FACTBOOK, <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html> (last visited Feb. 10, 2012).

⁷⁷ See Hermer, *supra* note 62, at 342–43.

⁷⁸ See *id.* at 344.

⁷⁹ See Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN'S L.J. 1, 16 (1997).

⁸⁰ Amy F. Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L. J. 849, 859 (2005) (discussing statistics from David M. Smolin's essay *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 MARQ. L. REV. 975 (1992)).

⁸¹ See Hermer, *supra* note 62, at 344.

⁸² *Id.*

⁸³ Cohen, *supra* note 80, at 859.

⁸⁴ *Id.*

maternal deaths.⁸⁵ As a result, the World Health Organization advises against the routine use of episiotomies.⁸⁶

The interventionist approach that obstetricians take to birthing is not the only problem; their very understanding about how long births “should take” can be dangerous for women. Many obstetricians practice “active management” in which a woman is not permitted to be in active labor more than twelve hours without delivery.⁸⁷ This approach is characterized by monitoring of the dilation of the cervix.⁸⁸ If the cervix does not dilate at least one centimeter per hour, the obstetrician will perform an amniotomy, which is breaking the bag of water in the uterus to speed up labor.⁸⁹ If there is no significant progress within one hour of the amniotomy, the obstetrician will then inject the mother with a drug, such as oxytocin, to artificially stimulate labor.⁹⁰ This timetable for birthing means that any woman who does not give birth after twelve hours of labor or does not respond quickly enough to the amniotomy or oxytocin could face a cesarean section and its associated risks.⁹¹ Inducing labor can lead to increased fetal distress, birth trauma, anesthetics, and cesarean section.⁹² Therefore, having an obstetrician attend a woman in labor can often result in unnecessary medical interventions which pose risks to both mother and baby.

Although both midwives and obstetricians can be sued, historically obstetricians have had a higher rate of lawsuits. In fact, even among medical doctors, obstetricians are more likely to be sued than any other specialist.⁹³ As a result, obstetricians often make unnecessary care decisions in order to prevent lawsuits.⁹⁴

⁸⁵ *Id.*

⁸⁶ *See id.*

⁸⁷ Hermer, *supra* note 62, at 331.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *See id.*

⁹² *See id.* at 348.

⁹³ *See* Falker, *supra* note 79, at 15.

⁹⁴ *See* MUHLHAHN, *supra* note 58, at 178.

This approach is referred to as “defensive medicine.”⁹⁵ For example, some hospitals have instituted a policy of always performing cesarean sections whenever a baby is breach because of the fear of litigation.⁹⁶ Yet this policy is not supported by data, since studies show that the increase in cesarean sections has not reduced the number of birth injuries.⁹⁷ In a malpractice suit, however, a plaintiff’s expert witness who testifies in order to establish the standard of care may state that a cesarean section could have saved the baby’s life or prevented post-natal complications.⁹⁸ Thus, anytime the obstetrician fears any complication or lawsuit, he or she may perform a cesarean section to avoid the suit. Indeed, some researchers have found that the odds of a cesarean section were 15% higher where a group of doctors had been sued multiple times within a four-year period.⁹⁹

The likelihood of malpractice claims in obstetrics is often the result of communication difficulties in the doctor-patient relationship.¹⁰⁰ Physicians’ very busy schedules and lack of time to spend with patients as well as their use of medical jargon are two factors that lead to poor communication between doctor and patient.¹⁰¹ Yet physicians may not be aware that they are communicating ineffectively. For example, one study showed that two-thirds of sued physicians thought they had been open and honest with their patients, but only one-third of their patients thought so.¹⁰² Moreover, a study of Florida obstetricians conducted by Vanderbilt University in Tennessee concluded that obstetricians who did not communicate effectively with their patients were more likely to be sued.¹⁰³ This study found that even

⁹⁵ See Falker, *supra* note 79, at 15.

⁹⁶ See *id.*

⁹⁷ See *id.* at 16.

⁹⁸ See, e.g., *id.* at 17 (discussing John M. Freeman and Andrew D. Freeman’s article *Cerebral Palsy and the ‘Bad Baby’ Malpractice Crisis: New York State Shines Light Toward the End of the Tunnel*, 146 AM. J. DIS. CHILD 725, 725 (1992)).

⁹⁹ See *id.* at 16.

¹⁰⁰ See *id.* at 7–8.

¹⁰¹ *Id.* at 8.

¹⁰² *Id.*

¹⁰³ *Id.* at 9.

where the care rendered was equivalent, obstetricians who did not communicate well were sued and those who communicated well were not sued.¹⁰⁴ The researchers conducting the study noted that physicians are sued frequently, but unsuccessfully.¹⁰⁵ Their data suggests that in many cases the animus behind the suit is likely the patient's dissatisfaction with the physician or his communication skills, rather than actual negligence by the physician.¹⁰⁶ Thus communication problems in the relationship can lead to malpractice suits, and malpractice suits can lead to doctors and patients viewing each other differently in the future. Doctors and patients increasingly see each other as opponents, with patients viewing doctors as potentially incompetent and doctors viewing patients as potential adversaries in litigation.¹⁰⁷

Authorities argue that women are not only dissatisfied with their communication with doctors, but that they also prefer birth experiences with less, rather than more, technological innovations.¹⁰⁸ This furthers the proposition that women are less likely to be satisfied with hospital births where obstetricians are likely to prescribe induction medication and epidurals, and to perform episiotomies, or cesarean sections.¹⁰⁹ Therefore, even where communication between the doctor and patient is satisfactory, the very procedures that are hallmarks of a hospital birth arguably make the birthing experience unsatisfactory to women.

Litigation in obstetrics is something of a vicious cycle. Patients feel ignored, so they sue obstetricians even where evidence of negligence is lacking. Physicians become distrustful of patients because they fear lawsuits. As a result, physicians perform more cesarean sections to try to avoid lawsuits. More cesarean sections mean more technical interventions in birth; therefore, women are less satisfied with birth experiences, making them more likely to sue. This starts the whole cycle over

¹⁰⁴ *Id.*

¹⁰⁵ *Id.* at 11.

¹⁰⁶ *Id.*

¹⁰⁷ *See id.* at 8.

¹⁰⁸ *See id.* at 27 (discussing the premise that women are more satisfied with less aggressive birthing experiences).

¹⁰⁹ *See supra* notes 93–107 and accompanying text.

again. The obstetrics model of care provokes litigation, leaving doctors and patients both dissatisfied.

2. The Midwifery Model as a Safe Alternative to Obstetrics

Studies have shown that home births can be as safe as hospital births for low-risk pregnancies.¹¹⁰ One large study targeting women who had non-emergency, planned, low-risk pregnancies at home found that the rate of maternal or infant death for home births was nearly the same as those births that occurred in hospitals.¹¹¹ A similar study compared 1707 planned home births attended by direct-entry midwives and found no significant differences between home births and hospital births in terms of fetal or neonatal death, labor related complications, or low five minute Apgar scores (which is a score of less than seven).¹¹² Because midwives allow women to labor as long as it is safe to do so, and do not induce labor unless it is necessary for either the baby's or mother's safety, women who birth at home with midwives are less likely to face the complications inherent in the labor-inducing methods often used at hospitals.¹¹³ These studies acknowledge, however, that hospital births have a significant safety advantage in cases where life-saving technology is immediately required.¹¹⁴ Thus, high-risk births should occur at hospitals while normal, low-risk births, can proceed safely at home.

¹¹⁰ See Johnson, *supra* note 7.

¹¹¹ *Id.*

¹¹² Durand, *supra* note 7. See also American Academy of Pediatrics, Committee on Fetus and Newborn; American College of Obstetricians and Gynecologists and Committee on Obstetric Practice, *The Apgar Score*, PEDIATRICS 117(4):1444-7 (Apr. 2006) available at <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;117/4/1444> (explaining that the Apgar test is used to assess a newborn infant's response to resuscitation. Apgar tests score five components: heart rate, respiratory effort, muscle tone, reflex irritability, and color. Each of these components is given a score of zero, one, or two).

¹¹³ See Hermer, *supra* note 62, at 347-48.

¹¹⁴ See Durand, *supra* note 7, at 452.

Midwives, like doctors, wish to avoid malpractice. The Midwifery Model of Care™ may result in fewer lawsuits because it involves less intrusive technology and more time for communication with patients.¹¹⁵ First, some midwives who attend home births care for one woman at a time,¹¹⁶ which may reduce the opportunity for women to feel rushed. It also allows the woman to ask as many questions as needed without the use of medical jargon. Second, midwives view birth as a natural process in which the woman is delivering her baby and the midwife is assisting in this process.¹¹⁷ Thus, midwives use fewer of the medical interventions discussed above and therefore expose women to fewer of the risks brought on by those interventions.¹¹⁸ Finally, if women are more satisfied with births involving fewer technological innovations,¹¹⁹ and midwives use the minimal amount necessary to deliver the baby, women are more likely to feel satisfied with the Midwifery Model of Care™.

Home births are also cheaper than hospital births. One in-depth economic analysis found that “an uncomplicated vaginal birth in a hospital in the United States cost on average three times as much as a similar birth at home with a midwife.”¹²⁰ This economic advantage is important, especially for expectant mothers who may not have insurance to cover their care.

Home births may also offer a more psychologically comfortable environment in which to give birth. Giving birth at home means the woman, her family, friends, and the midwife can make decisions based on the mother’s comfort and safety, not based on freeing up beds or avoiding malpractice claims.¹²¹ Because giving birth is such a significant and often stressful event in a woman’s life, it makes sense for women to be in a familiar environment rather than in the large institutional setting of a

¹¹⁵ See *Midwifery Definitions*, *supra* note 3.

¹¹⁶ MUHLHAHN, *supra* note 58, at 178.

¹¹⁷ See *Midwifery Definitions*, *supra* note 3.

¹¹⁸ See Hermer, *supra* note 62, at 340.

¹¹⁹ See Falker, *supra* note 79, at 27–28.

¹²⁰ Johnson, *supra* note 7 at 1419.

¹²¹ See MUHLHAHN, *supra* note 58, at 178.

hospital.¹²² A woman giving birth at home has the full attention of the midwife,¹²³ is free to walk around, or to take any physical position that helps her during the labor.¹²⁴ Because women have the time and individualized attention that they need in a comfortable and familiar setting, birthing at home can be a more comfortable option for many women.

3. Why Obstetricians Oppose Home Births

Despite the fact that home births are generally safe, lead to less litigation, and are more likely to be satisfying for women, obstetricians still oppose home birth. Even though the American Public Health Association and the World Health Organization have both endorsed home birthing,¹²⁵ the American College of Obstetricians and Gynecologists (“ACOG”) continues to oppose it.¹²⁶ Yet, the ACOG’s opposition to home births seldom seems to reflect the reality of what home births are like. For example, the ACOG stated in a February 2008 press release that it opposed home births because babies need constant monitoring during birth.¹²⁷ This implies, erroneously, that midwives do not monitor babies throughout the birthing process.¹²⁸ In fact, midwives use a Doppler instrument to monitor babies throughout the birthing process, and this monitoring method is more likely to prevent a cesarean section than some hospital fetal monitoring methods.¹²⁹ Thus, the American medical community

¹²² *See id.*

¹²³ *See id.* at 179.

¹²⁴ *Id.*

¹²⁵ Johnson, *supra* note 7, at 1416; *Care in Normal Birth: A Practical Guide*, WORLD HEALTH ORGANIZATION (1996), available at www.who.int/making_pregnancy_safer/documents/who_frh_msm_9624/en/ (discussing findings that home birth and midwifery can be a safe alternative to hospital delivery).

¹²⁶ *See* ACOG, *supra* note 6.

¹²⁷ MUHLHAHN, *supra* note 58, at 160–61.

¹²⁸ *See id.* at 161.

¹²⁹ The Doppler is a non-invasive device. *See id.* at 161–65 (explaining that a Doppler is an instrument held to a pregnant woman’s stomach in order to monitor the baby’s heart rate).

continues to oppose home births based on incorrect claims about safety that have been debunked by numerous studies.

Many other countries do not suffer from the same schism between the medical and midwifery communities. For example, in the United Kingdom, the Royal College of Midwives and the Royal College of Obstetricians and Gynecologists put out a joint statement supporting home birth for low-risk pregnancies because home birth increases the likelihood of having a safe and satisfying birth.¹³⁰ Midwives attend around 70% of births in the European Union.¹³¹ Perhaps some American medical doctors' opposition to home birth stems from the fact that the majority have never witnessed it,¹³² particularly since, over the past fifty years home births have remained relatively rare in the United States. If doctors have not observed the birthing process at home with the help of a midwife they might believe that the midwives are unskilled rebels with no services to offer women. In reality, midwives, including direct-entry midwives, are equipped with the tools necessary to monitor and assist birth without being intrusive.¹³³ Moreover, when these midwives encounter conditions requiring medical attention they identify it and take the mothers to the hospital.¹³⁴ It follows then that doctors have nothing to fear about home births, if only they would take the time to understand how they actually proceed.

4. Both Midwifery and Obstetrics Have a Role to Play

Although obstetricians have traditionally viewed midwives as their rivals and many obstetricians continue to hold that view,¹³⁵ both the obstetrical model and the midwifery model of child-birth have their place. In high-risk pregnancies, there is no

¹³⁰ *Id.*

¹³¹ Cohen, *supra* note 80, at 868.

¹³² See MUHLHAHN, *supra* note 58, at 171 (discussing her suspicion that most obstetricians have never observed a midwife deliver a baby in the home).

¹³³ *Midwifery Definitions*, *supra* note 3 (explaining that as part of the Midwifery Model of Care™, midwives transfer high-risk cases to the hospital).

¹³⁴ *Id.*

¹³⁵ See Storck, *supra* note 4, at 93.

doubt that sophisticated medical procedures help both mother and child.¹³⁶ No midwife who cares about her patients or any expectant mother would hope for the abolition of obstetrics, a field that protects women and their infants. However, obstetricians need not fear midwives. Midwives perform a much needed service for women when they deliver babies at home, and can provide women with the support they need to begin a healthy mother-child relationship. Since midwives pose no threat to women and often improve their lives, obstetricians ought to support both certified nurse and direct-entry midwives. If each occupation focuses on the distinct services it can render, the two fields can peacefully, and even lucratively, co-exist.

C. The Campaigns for Legal Recognition of Midwifery

Midwifery advocates have attempted to gain recognition of the right to choose midwifery both through constitutional litigation and legislative lobbying. This section will discuss their attempts at each level and the results of those campaigns.

1. A Constitutional Right to Choose Childbirth Methods

Over the past few decades, direct-entry midwives have challenged laws against their practice.¹³⁷ Midwives have argued that prohibitions against direct-entry midwives infringe upon their right to employment.¹³⁸ The right to pursue a chosen profession is a property right protected by the Fifth and Fourteenth Amendments and restrictions on this right are reviewed on a rational-basis standard.¹³⁹ Thus, the state may only impose restrictions on the right to pursue a chosen profession where the

¹³⁶ See Durand, *supra* note 7, at 452.

¹³⁷ Courts have rejected the constitutional challenges brought by midwives. See generally *Bowland v. Mun. Court*, 556 P.2d 1081 (Cal. 1976); *People v. Rosburg*, 805 P.2d 432, 439 (Colo. 1991); *Hunter v. State*, 676 A.2d 968 (Md. 1996); *Lange-Kessler v. N.Y. Dep't Educ.*, 109 F.3d 137 (2d Cir. 1997); *State v. Kimpel*, 665 So. 2d 990 (Ala. Crim. App. 1995); *Leigh v. Bd. of Registration in Nursing*, 506 N.E.2d 91 (Mass. 1987).

¹³⁸ See *Lange-Kessler*, 109 F.3d at 140.

¹³⁹ *Id.* at 140.

restrictions are rationally related to a legitimate state interest.¹⁴⁰ Courts have consistently found that the restriction on direct-entry midwifery is rationally related to the state's legitimate interest in the health and welfare of mothers and infants.¹⁴¹ Because midwives and obstetricians disagree about the safety of midwifery, a court may conclude that "reasonable minds [can] differ" about this issue.¹⁴² Therefore, it is rational for the legislature to choose one line of reasoning over the other.¹⁴³ The problem with this approach is that it does not investigate whether the claims of the obstetricians about midwifery are actually rational. If the courts examined the obstetricians' reasoning, they would likely discover that the physicians' lobby has repeatedly exaggerated claims of danger¹⁴⁴ or ignored the fact that midwives screen out high-risk pregnancies.¹⁴⁵ Courts assume obstetricians are rational, and thus conclude that the legislature is rational in siding with them,¹⁴⁶ but these conclusions are not based in an actual consideration of the obstetricians' claims. Nonetheless, under the lax standard of rational basis, legislation prohibiting midwifery has always been held to be constitutional.¹⁴⁷

Midwives also argue, on behalf of their clients, that a woman's right to have her baby at home with the attendant of her choice

¹⁴⁰ *Id.*

¹⁴¹ Courts have specifically rejected the argument that choice of childbirth attendant is included in the right to privacy. *See, e.g., Rosburg*, 805 P.2d at 437-39; *Hunter*, 676 A.2d at 975-76; *Lange-Kessler*, 109 F.3d at 142; *Kimpel*, 665 So. 2d at 994; *Leigh*, 506 N.E. 2d at 94.

¹⁴² *See Lange-Kessler*, 109 F. 3d at 141.

¹⁴³ *See id.*

¹⁴⁴ *See generally* Beckett, *supra* note 27, at 152-54 (discussing various statements by opponents of midwifery that attack the practice).

¹⁴⁵ *See id.* (opponents state that technology saves lives and ignores the fact that midwives transfer women to hospitals in high-risk situations).

¹⁴⁶ *See Rosburg*, 805 P.2d at 437-39; *Hunter*, 676 A.2d at 975-76; *Lange-Kessler*, 109 F.3d at 142; *Kimpel*, 665 So. 2d at 994; *Leigh*, 506 N.E. 2d at 94.

¹⁴⁷ *See Rosburg*, 805 P.2d at 437-39; *Hunter*, 676 A.2d at 975-76; *Lange-Kessler*, 109 F.3d at 142; *Kimpel*, 665 So. 2d at 994; *Leigh*, 506 N.E. 2d at 94.

is encompassed in the right to privacy¹⁴⁸ recognized in decisions like *Griswold v. Connecticut*,¹⁴⁹ *Eisenstadt v. Baird*,¹⁵⁰ and *Roe v. Wade*.¹⁵¹ Midwives argue that the choice of whom to trust to assist in childbirth and where to give birth are important aspects of the right to privacy just as the right to marital privacy, contraception, and abortion.¹⁵² The underlying rationale is that giving birth is at least as significant in the lives of women as the choice to avoid giving birth, use contraception, or have an abortion.¹⁵³ By this logic, the same privacy interest that protects a woman from unreasonable state interference in her choice for a first trimester abortion ought to protect her choice to carry a baby to term and have it delivered by a midwife. However, these arguments have also been largely unsuccessful.¹⁵⁴ Courts have consistently read *Roe* to apply only to early term abortions and not to relate to childbirth choices at all.¹⁵⁵ These decisions are based on the reasoning that there is no evidence from *Roe* that the Supreme Court intended for the decision to apply outside the context of a pre-viability choice to abort.¹⁵⁶ Instead, courts consider the choice of a midwife for birth to be akin to choosing a healthcare provider, which has never been held to be part of the right to privacy.¹⁵⁷ Courts have rejected the inclusion of birthing rights in the constitutional right to privacy over the past thirty

¹⁴⁸ See *Bowland v. Mun. Court*, 556 P.2d 1081, 1089 (Cal. 1976) (discussing previous Supreme Court rulings establishing the right to privacy regarding contraception and abortion).

¹⁴⁹ 381 U.S. 479, 485–86 (1965).

¹⁵⁰ 405 U.S. 438, 453–54 (1972).

¹⁵¹ 410 U.S. 113, 152–53 (1973).

¹⁵² *Bowland*, 556 P.2d at 1088–89.

¹⁵³ See *id.*

¹⁵⁴ See *Bowland*, 556 P.2d at 1089; *Rosburg*, 805 P.2d at 437; *Hunter*, 676 A.2d at 975–76; *Lange-Kessler*, 109 F.3d at 141–42; *Kimpel*, 665 So. 2d at 994; *Leigh*, 481 N.E.2d at 1354.

¹⁵⁵ See *Bowland*, 556 P.2d 1081; *Rosburg*, 805 P.2d 432; *Hunter*, 676 A.2d 968; *Lange-Kessler*, 109 F.3d 137; *Kimpel*, 665 So. 2d 990.

¹⁵⁶ See *Bowland*, 556 P.2d 1081; *Rosburg*, 805 P.2d 432; *Hunter*, 676 A.2d 968; *Lange-Kessler*, 109 F.3d 137; *Kimpel*, 665 So. 2d 990.

¹⁵⁷ See *Bowland*, 556 P.2d 1081; *Rosburg*, 805 P.2d 432; *Hunter*, 676 A.2d 968; *Lange-Kessler*, 109 F.3d 137; *Kimpel*, 665 So. 2d 990.

years.¹⁵⁸ Thus, it seems unlikely that courts will recognize such a right in the near future.

In addition to the employment and privacy rights arguments, scholar Amy Cohen has argued that a bodily integrity right is at issue in midwifery law as well.¹⁵⁹ She contends that by prohibiting midwifery, the state forces a woman to have hospital births which subsequently puts the woman at higher risk for cesarean section or episiotomy.¹⁶⁰ Cohen asserts that forcing women to be exposed to these invasive procedures violates the woman's right to bodily integrity.¹⁶¹ To support her position, Cohen analogizes to bodily-integrity cases in the criminal defense context.¹⁶² For example, in *Winston v. Lee*, the Court held that forcing a criminal defendant to have bullets removed from his body to be used as evidence against him violates the individual's bodily integrity.¹⁶³ Moreover, in *Rochin v. California*, the Court held that forcing stomach pumping in order to procure evidence violated the right to privacy under constitutional law.¹⁶⁴ Cohen maintains that forcing women into hospital birthing situations where an unnecessary cesarean section is likely to occur also constitutes a violation of bodily integrity.¹⁶⁵ Yet Cohen's argument fails to recognize the difference between the state ordering a surgeon to open someone's body and the state regulating childbirth such that a woman is more likely to submit to a surgeon opening her body. The difference is in the degree of coercion involved. Increasing the likelihood of surgery is simply not as coercive as ordering it to be performed on an unwilling individual. Thus, while Cohen's argument is worth considering, it seems unlikely that it would actually be successful.

¹⁵⁸ See *Bowland*, 556 P.2d 1081; *Rosburg*, 805 P.2d 432; *Hunter*, 676 A.2d 968; *Lange-Kessler*, 109 F.3d 137; *Kimpel*, 665 So. 2d 990.

¹⁵⁹ See Cohen, *supra* note 80, at 869–70.

¹⁶⁰ *Id.* at 869–70.

¹⁶¹ *Id.* at 870.

¹⁶² *Id.*

¹⁶³ *Id.* (citing *Winston v. Lee*, 470 U.S. 753, 764–65 (1985)).

¹⁶⁴ *Id.* (citing *Rochin v. California*, 342 U.S. 165, 166, 174 (1965)).

¹⁶⁵ *Id.*

In conclusion, the right to employment, the right to privacy, and the right to bodily integrity arguments in favor of a right to choose a midwife are all unlikely to succeed. Thus, midwives must advocate for legalization on a state-by-state basis.

2. The States That Allow Direct-Entry Midwifery

Twenty-six states currently allow direct-entry midwifery and have some form of licensure or regulation in place.¹⁶⁶ Two additional states allow direct-entry midwifery by state statute, but do not have any form of licensure or regulation in place.¹⁶⁷ Nine additional states allow direct-entry midwifery by judicial interpretation but do not have licensure or regulation in place.¹⁶⁸ Furthermore, in four states direct-entry is not legally defined, but also is not prohibited.¹⁶⁹ As a result, in forty-one states direct-entry midwifery is not prohibited.

In considering the way forward for the midwifery lobby in Illinois, it is valuable to consider how other states passed similar midwifery licensure bills. For instance, midwifery advocates in other states concluded that when legislators created an atmosphere of anticipation and expected the midwives and the doctors to come to some agreement, it became easier to negotiate.¹⁷⁰ The midwifery advocates in Vermont stated that they felt the pressure from the legislature for the medical and midwifery communities to compromise.¹⁷¹ This resulted in the medical community sitting down to negotiate for the first time.¹⁷² This kind of pressure can be created, in part, by assuring the legislators that the midwives are willing to make some compromises with the medical community if only the medical community will

¹⁶⁶ *Direct Entry Midwifery State-by-State Legal Status*, MIDWIVES ALLIANCE OF NORTH AMERICA, <http://mana.org/statechart.html> (last visited Feb. 10, 2012).

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ See, e.g., Hoffman, *supra* note 26, at 108.

¹⁷¹ See *id.*

¹⁷² See *id.*

sit down at the table. Thus, midwifery advocates in Illinois should do their best to encourage the expectation in legislators' minds that not achieving a compromise constitutes failure.

The experience of the midwifery lobby in other states also demonstrates that persistence is crucial in order to pass legislation. In some cases, legislators feel that the debate should happen several times to ensure that all sides have a chance to be heard on a given issue.¹⁷³ For example, a legislator in Indiana stated that she did not think home birth should be a crime, she "just thought it was an issue that needed more . . . to be brought before us just a little bit more."¹⁷⁴ Given legislators' preference for legislation that has been brought before them multiple times, Illinois activists should be persistent in pursuing legislation each session.

In other states, just as in Illinois, the medical community tends to use hyperbolic statements and emotive anecdotes, rather than scientific findings, to oppose direct-entry midwifery legislation.¹⁷⁵ Given that this approach seems to be widespread, midwifery activists need to be ready to combat the fear-mongering calmly and persistently. Advocates of direct-entry midwifery must continue to calmly ask their opponents for scientific proof of their statements that midwifery is unsafe. The Illinois Medical Society, just like any other lobbying group, ought to be required to show evidence of its statements that midwifery is unsafe rather than being permitted to repeat their misguided fears.¹⁷⁶

In sum, if forty-one states, each with distinct populations, political climates, and cultures, are able to allow direct-entry midwifery, then Illinois has no excuse for prohibiting the practice. Illinois midwifery advocates should learn from these forty-one examples and continue to struggle for childbirth rights.

¹⁷³ See *id.* at 105–06.

¹⁷⁴ *Id.* at 106.

¹⁷⁵ See *id.* at 118.

¹⁷⁶ *Infra* notes 213–14 and accompanying text.

III. ANALYSIS: MIDWIFERY LAW IN ILLINOIS

Illinois law currently permits certified nurse-midwives but prohibits direct-entry midwifery.¹⁷⁷ When direct-entry midwives do practice they can be charged with practicing nursing or nurse midwifery without a license if they assist with home births.¹⁷⁸ This section will discuss the statutes and case law that govern direct-entry midwifery in Illinois as well as how midwifery policy in Illinois might be improved.

A. *Statutory Prohibitions*

Current statutory law does not specifically prohibit direct-entry midwifery by name. Instead, the state often uses the statutes against the practice of nursing or nurse-midwifery by unlicensed persons in order to prosecute midwives.¹⁷⁹ The statute proscribing practicing medicine without a license states:

No person shall practice medicine, or any of its branches, or treat human ailments without the use of drugs and without operative surgery, without a valid, existing license to do so, except that a physician who holds an active license in another state or a second year resident . . . may provide medical services to patients in Illinois during a bonafide emergency in immediate preparation for or during interstate transit.¹⁸⁰

Notice how broad the language in this statute is. The statute defines “treating human ailments” as practicing medicine, without defining what it means to treat an ailment. No examples of “treating ailments” are given. The legislature could have de-

¹⁷⁷ Direct-entry midwives in Illinois have been prosecuted for practicing medicine without a license. See generally *People ex rel. Sherman v. Cryns*, 786 N.E.2d 139 (Ill. 2003); *Morris v. Dep’t of Prof’l Regulation*, 824 N.E.2d 1151 (Ill. App. Ct. 2005).

¹⁷⁸ See generally *Cryns*, 786 N.E.2d 139; *Morris*, 824 N.E.2d 1151.

¹⁷⁹ See *Cryns*, 786 N.E.2d at 158; *Morris*, 824 N.E.2d at 1158–59.

¹⁸⁰ 5 ILL. COMP. STAT. 80/4.22 (2011) (On November 23, 2011 the legislature extended this act until December 31, 2012, after which it is set for repeal.).

defined practicing medicine as relating to medical science or relating to pathology, but instead made the definition so broad that it necessarily encompasses non-medical practices like midwifery¹⁸¹ and acupuncture.¹⁸²

The statute regulating nursing is similarly broad. The following acts are considered to be the practice of nursing:

- (1) the assessment of healthcare needs, nursing diagnosis, planning, implementation, and nursing evaluation;
 - (2) the promotion, maintenance, and restoration of health;
 - (3) counseling, patient education, health education, and patient advocacy;
 - (4) the administration of medications and treatments as prescribed by a physician licensed to practice medicine . . .
 - (5) the coordination and management of the nursing plan of care;
 - (6) the delegation to and supervision of individuals who assist the registered professional nurse implementing the plan of care; and
 - (7) teaching nursing students.
- The foregoing shall not be deemed to include those acts of medical diagnosis or prescription of therapeutic or corrective measures.¹⁸³

Performing any of these acts without a license is a crime under the statute and is punishable by fines, probation, or criminal penalties.¹⁸⁴ Yet this language obviously encompasses activities by non-nurses. There are legions of alternative healthcare providers who participate in the “promotion, maintenance, and restoration of health” but are not nurses.¹⁸⁵ By casting its net so widely, this statute “catches” all kinds of non-nurses who are

¹⁸¹ See generally *Cryns*, 786 N.E.2d 139; *Morris*, 824 N.E.2d 1151.

¹⁸² See *Mitchell v. Clayton*, 995 F.2d 772 (7th Cir. 1993).

¹⁸³ 225 ILL. COMP. STAT. 65/50-10 (2009).

¹⁸⁴ See *Morris*, 824 N.E.2d 1151 (A midwife was placed on probation for practicing without a license.); *People v. Jihan*, 537 N.E.2d 752, 753 (Ill. 1989) (A midwife was charged with manslaughter.).

¹⁸⁵ See generally Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273 (1996) (comparing how alternative health care providers are regulated versus how nurses and doctors are regulated).

helping their clients and doing no harm. A more narrowly-drawn statute could have prohibited dangerous activity such as non-nurses posing as nurses in a medical setting while simultaneously allowing non-medical activities like direct-entry midwifery to continue. Instead the state persists with prosecuting midwives under this broad language.

B. The Recent Midwifery Case Law in Illinois

In trying to understand current midwifery regulation in Illinois it is important to examine past statutes and case law. Though the current statutes discussed above make no mention of direct-entry midwifery, a former statute did specifically prohibit direct-entry midwifery. That statute, the then-existing Illinois Medical Practice Act, was held unconstitutionally vague in *People v. Jihan*.¹⁸⁶ In that case, the defendant midwife was charged with practicing midwifery without a license.¹⁸⁷ The court held that the Act did not provide a clear enough definition of which activities were considered to be “practicing midwifery” and therefore the statute was unconstitutional due to vagueness.¹⁸⁸ The court reasoned that the distinction between “delivering” the child and “assisting with birth” was not made clear enough in the Act.¹⁸⁹ By the time the opinion was published, the Illinois Medical Practice Act had been repealed and the current version of the statute, which does not mention midwifery by name, was enacted.¹⁹⁰

Since direct-entry midwifery was not legalized as a result of the case, it was only a temporary victory for midwives when the then-existing statute was overturned due to vagueness. Moreover, as will become evident below, Illinois continued to prose-

¹⁸⁶ *Jihan*, 537 N.E.2d at 756.

¹⁸⁷ *Id.* at 752.

¹⁸⁸ *See id.* at 755.

¹⁸⁹ *Id.*

¹⁹⁰ *Id.* at 756 (“[T]he Act in question here has been repealed by the General Assembly and replaced by the Medical Practice Act of 1987.”). *See* 5 ILL. COMP. STAT. 80/4.22 (2011).

cute midwives, just under the new statute.¹⁹¹ But *People v. Jihan*, and other cases like it, does serious damage to the reputation of direct-entry midwifery because the case involves an incompetent midwife. In *Jihan*, the midwife realized that the child's airways were likely to be blocked and advised the parents to go to the hospital, but they declined.¹⁹² When the baby's head was delivered, the defendant suctioned the blockage from the baby's nose.¹⁹³ She cut the umbilical cord, told her assistant to call an ambulance, and brought the baby into a bathroom full of steam to help the baby breathe.¹⁹⁴ The defendant could not get the baby to breathe.¹⁹⁵ After transport in the ambulance, the baby was pronounced dead upon arrival at the hospital.¹⁹⁶

The *Jihan* case gives the false impression that all home births are quite dangerous. If used as an example of direct-entry midwifery, it suggests that home births involve midwives who have no formal midwifery training, clients who refuse to take an infant to the hospital, and babies who die as a result. This is certainly not typical of home births and not an accurate impression of midwives.¹⁹⁷ The vast majority of the hundreds of safe home births that occur in Illinois each year¹⁹⁸ do not result in such tragic consequences, nor do they end up in court. Thus, the public and the courts hear only about the botched cases. In reality,

¹⁹¹ See, e.g., *People ex rel. Sherman v. Cryns*, 786 N.E.2d 139 (Ill. 2003) (using the new version of the law, a midwife was prosecuted for practicing nursing without a license); *Morris v. Dep't of Prof'l Regulation*, 824 N.E.2d 1151 (Ill. App. Ct. 2005) (using the new version of the law, a midwife was placed on probation for practicing nursing without a license).

¹⁹² *Jihan*, 537 N.E.2d at 752.

¹⁹³ *Id.* at 753.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.*

¹⁹⁶ *Id.*

¹⁹⁷ See Johnson, *supra* note 7.

¹⁹⁸ *Midwifery Licensure Act: Hearings on S.B. 385 Before the S. Licensed Activities Comm.*, 95th Gen. Assemb. (2007) [hereinafter *Hearings on S.B. 385*] (statement of Mr. Dan Johnson-Weinberger for the Coalition for Illinois Midwifery that hundreds of home births occur each year; presumably, since these are not subsequently reported as infant or maternal mortalities, they are safe).

tragic cases resulting in infant death can occur in home births and hospitals, but are equally rare in both locations.¹⁹⁹

In a more recent midwifery regulation case, the court justified the prosecution of the midwife on the basis that the midwife used various medical instruments in the course of the childbirth.²⁰⁰ In *People v. Cryns*, the court found that since the midwife ascertained the baby's health status using a fetoscope to listen to the heartbeat and tried to resuscitate the baby, the midwife was assessing the healthcare needs of the mother and baby; making nursing evaluations; attempting to promote, maintain, and restore the baby's health; and attempting corrective measures to improve the baby's status.²⁰¹ The court found that all of these activities are "practicing nursing" under the Nursing Act and constituted a prima facie case against the midwife.²⁰²

Even if there was a valid claim of liability against this midwife, it seems illogical to use the nursing statute to hold her accountable. Opponents of midwifery often cite safety concerns as the rationale for their opposition,²⁰³ yet when a midwife takes steps to save a baby's life, those steps become the evidence of her wrongdoing. It is paradoxical to complain about the lack of safety of midwifery and then to prosecute a midwife for trying to save a baby's life. This illogical approach shows that the current method for regulating midwifery, namely outlawing it via vague nursing statutes, is not working.

A law permitting, but also heavily regulating, the practice of direct-entry midwifery in Illinois would allow the state to make a more straightforward case about the midwife's liability. For example, if the midwife should have recognized this as a high-risk birth and sent the woman to the hospital, a midwifery statute could compel that action and the case against the midwife

¹⁹⁹ For a discussion of the safety of midwifery practice, see generally Johnson, *supra* note 7.

²⁰⁰ See *People ex rel. Sherman v. Cryns*, 786 N.E.2d 139, 155 (Ill. 2003).

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ See ACOG, *supra* note 6 (citing safety concerns as the reason for the opposition to midwifery).

would be clear. Under current law, the court is forced into awkward acrobatics of interpretation that imply the problem was the use of medical instruments. Instead, the problem was likely that the midwife did not recognize the signs of a high-risk birth and did not send the woman to a hospital. A statute regulating direct-entry midwifery could hold her accountable for this error rather than pretending her attempts to save the baby's life were the error.

C. Direct-Entry Midwifery Should Be Legalized and Regulated in Illinois

Cases like *Jihan* and *Cryns* accurately portray the danger in not allowing and regulating direct-entry midwifery. In those cases, potentially unqualified midwives, without the regulation of NARM and the Certified Professional Midwife licensure, attempted to assist with home births but ultimately were not able to save the babies' lives.²⁰⁴ While the babies may have died even if they have been born under the care of a physician, the midwives' lack of licensure creates an open question as to whether the deaths were the result of the midwives' actions. Continued total prohibition of direct-entry midwives could lead to more harm for patients.²⁰⁵ Women may proceed without a midwife rather than go to a hospital, or a midwife may not take a woman in crisis to a hospital due to the midwife's fear that she may face criminal charges.²⁰⁶ Yet both *Jihan* and *Cryns* also demonstrate that there are families in Illinois who prefer midwives to hospital births, even when fully informed that the midwife is not medically trained. Despite this demand for direct-entry midwifery, because the practice is still illegal, the legislature cannot regulate it and ensure safety. Thus, it would be wise for Illinois to allow the practice and regulate it thoroughly.

²⁰⁴ See, e.g., *People v. Jihan*, 537 N.E.2d 751 (Ill. 1989); *Cryns*, 786 N.E.2d 139.

²⁰⁵ Susan Corcoran, *To Become a Midwife: Reducing Legal Barriers to Entry into the Midwife Profession*, 80 WASH. U. L. Q. 649, 666 (2002).

²⁰⁶ See *id.*

Well regulated direct-entry midwifery with clear requirements for credentialing is the ideal system for allowing women to choose which childbirth option is best for them. Licensure would allow midwives to know with certainty that they are practicing within the scope of the law and allow clients to ensure that the midwives they choose are qualified. Illinois should link the state license to practice midwifery to the certification process of NARM. Midwives who achieve the CPM certification through NARM would thus be permitted to practice. This would reduce the administrative duties of the state, since Illinois would only have to verify a midwife's status through NARM, rather than administering its own individual certification process. This type of licensure requirement has already been implemented successfully in twenty-one states.²⁰⁷

As discussed in Part III of this article, allowing direct-entry midwifery reduces the cost for low-risk births and increases the satisfaction of women with their birthing experience. This reduction in cost is particularly significant for the poor. As of 2008, 12.2% of the Illinois' population lived in poverty.²⁰⁸ Pregnant women who fall into this category would benefit from the option of a less expensive, less invasive, and more empowering birthing process. Additionally, more than six thousand Amish people live in Illinois²⁰⁹ and some have informed the Illinois legislature that they would prefer a legal home birthing option.²¹⁰ Since midwifery is a safe and advantageous option for so many of Illinois' citizens, the state should allow home birth.

²⁰⁷ *Direct Entry Midwifery State-by-State Legal Status*, *supra* note 2.

²⁰⁸ AMY TERPSTRA ET AL., SOCIAL IMPACT RESEARCH CENTER 2010 REPORT ON ILLINOIS POVERTY (2010), <http://www.heartlandalliance.org/whatwedo/advocacy/reports/2010-report-on-illinois-poverty.html>.

²⁰⁹ *Amish Population by State*, AMISH STUDIES (2007), http://www2.etown.edu/amishstudies/Population_by_State.asp (last visited Feb. 10, 2012).

²¹⁰ *Hearings on S.B. 385*, *supra* note 198(statement of Pat Cole, Illinois Families for Midwifery, reading a letter from an Amish community).

D. The Attempts Over the Past Ten Years to Legalize Direct-Entry Midwifery in Illinois

Advocates for direct-entry midwifery have tried several times over the past ten years to pass legislation making direct-entry midwifery legal in Illinois.²¹¹ For example, in March of 2001, a bill was proposed in the House of Representatives in the Registration and Regulation Committee that would have allowed for certified professional midwife licensure.²¹² Proponents noted that midwives were licensed in the state until 1963 and wanted to become legal and licensed again.²¹³ Opponents of the bill raised the concern that uneducated women attending these births would not know how to perform a cesarean section.²¹⁴ This statement ignored the professional obligation of midwives to transfer a woman to the hospital if she was in danger or required a cesarean section.²¹⁵ Advocates then amended that legislation to ensure that the education required of direct-entry midwives be through a program accredited by the Midwifery Education Accreditation Counsel (“MEAC”).²¹⁶ MEAC sets the standards for midwifery education to ensure that midwives with the CPM credential actually have the training they need to effectively and safely assist women in giving birth.²¹⁷ Even with this amendment to allow for clear credentialing, the Illinois legislators on the committee were still not persuaded. The bill died

²¹¹ The following bills would have made direct-entry midwifery legal in Illinois if they had passed: H.B. 226, 96th Gen. Assemb. (Ill. 2009); H.B. 4440, 95th Gen. Assemb. (Ill. 2008); S.B. 385, 95th Gen. Assemb. (Ill. 2007); H.B. 645, 95th Gen. Assemb. (Ill. 2005); H.B. 3129, 93d Gen. Assemb. (Ill. 2003); H.B. 577, 92d Gen. Assemb. (Ill. 2001).

²¹² Ill. H.B. 577.

²¹³ See *The Certified Professional Midwife Licensure Act: Hearing on H.B. 577 Before the H. Registration and Regulation Comm.*, 92d Gen. Assemb. (Ill. 2001) [hereinafter *Hearing on H.B. 577*] (statement of Kenneth Ruinous, attorney).

²¹⁴ *Id.* (statement of Joyce Nardulli, Illinois Medical Society).

²¹⁵ See *Midwifery Definitions*, *supra* note 3 (explaining that the Midwifery Model of Care™ involves transferring women in need of obstetrical care).

²¹⁶ Ill. H.B. 577 (amendment number one).

²¹⁷ See MIDWIFERY EDUCATION ACCREDITATION COUNCIL, <http://meacschools.org/about.php?ID=1> (last visited Feb. 10, 2012).

in committee with a vote of three in favor, twelve against, and three abstentions.²¹⁸

The Illinois midwifery activists would not give up. In 2003, the midwives' allies in the House proposed Certified Professional Midwife Licensure Act²¹⁹ once again in the Registration and Regulation Committee.²²⁰ Advocates stated that the purpose of the Act was to protect midwives from being prosecuted for delivering babies.²²¹ One opponent stated that licensure of midwives was the equivalent of stating that the midwives were "as good as" doctors.²²² An advocate for the bill responded that the midwives were not trying to be doctors, just trying to deliver babies.²²³ Indeed, by stating that midwives were trying to be "as good as doctors," opponents of the bill confused the issue. The midwifery model for birthing proposes an alternative to the medical model of childbirth and is not the same as medicine.²²⁴ Direct-entry midwives acknowledge that the Midwifery Model of Care™ is only advisable for low-risk births; high-risk births certainly are the purview of doctors.²²⁵ Thus, the opponents of the bill, either purposefully or negligently, misunderstood its purpose and the nature of midwifery. This bill, like the previously discussed bill, never made it out of committee because the vote was three in favor, eleven against, with no abstentions.²²⁶

In 2005, midwifery advocates once again brought their cause before the Committee on Regulation and Registration.²²⁷ This time, instead of arguing that the midwives wanted licensure, or deserved to practice without being prosecuted, the advocates of

²¹⁸ *Hearing on H.B. 577, supra* note 213.

²¹⁹ Ill. H.B. 3129.

²²⁰ *The Certified Professional Midwife Licensure Act: Hearing on H.B. 3129 Before the H. Registration & Regulation Comm., 93d Gen. Assemb. (Ill. 2003)* [hereinafter *Hearing on H.B. 3129*].

²²¹ *Id.* (statement of Rep. Flowers).

²²² *Id.* (statement of Rep. Mulligan).

²²³ *Id.* (statement of Rep. Flowers).

²²⁴ *See Midwifery Definitions, supra* note 3 (explaining the Midwifery Model of Care™ involves transferring women in need of obstetrical care).

²²⁵ *See id.*

²²⁶ *Hearing on H.B. 3129, supra* note 220.

²²⁷ Ill. H.B. 645.

the bill argued that the bill would protect consumers by regulating midwives.²²⁸ The proponents of the bill emphasized that prosecuting midwives had not actually stopped the practice, and that families were still seeking midwives.²²⁹ Thus, the advocates presented the bill as a means of protecting consumers who were seeking midwifery services, whether such services were legal or illegal. A public health advocate explained that the midwifery model of childbirth has been studied extensively and that at that time nineteen states allowed direct-entry midwifery.²³⁰ Opponents of the bill, specifically a representative of the Illinois State Medical Society, stated that the bill would license people to do medical care that they are not trained to perform.²³¹ Even though the advocates of the bill used different reasons for supporting the bill than in previous debates, the opponents of the bill still used the same erroneous fears about the safety of midwifery and confused midwifery with the practice of medicine. The committee voted seventeen to six with no abstentions to quash the bill and not send it to the floor of the House for a vote.²³²

During discussion of the bill, legislators also indicated some of their concerns about the legislation. They expressed concern as to whether or not the midwives would carry liability insurance if the bill were passed.²³³ Representatives of the midwives said that midwives would be liable, however, most midwives do not carry insurance because they do not attend high-risk births.²³⁴ The midwives mentioned that Florida does require direct-entry midwives to carry insurance.²³⁵ This concern about insurance is important to remember when one considers the future of direct-

²²⁸ *The Certified Professional Midwife Licensure Act: Hearing on H.B. 645 Before the H. Registration & Regulation Comm., 94th Gen. Assemb. (Ill. 2005)* (statement by Tracey Johnstone, midwife).

²²⁹ *Id.*

²³⁰ *Id.* (statement of Michelle Breen, public health advocate).

²³¹ *Id.* (statement of Erin O'Brien, Illinois State Medical Society).

²³² *Id.*

²³³ *Id.* (statement of Rep. Mulligan).

²³⁴ *Id.* (statement of Tracey Johnstone in response to Rep. Mulligan).

²³⁵ *Id.*

entry midwifery legislation in Illinois, as it may be pivotal in convincing legislators of the viability of allowing direct-entry midwives to practice. All future bills allowing for direct-entry midwifery should make insurance mandatory for midwives in order to persuade the greatest number of legislators that midwifery is a safe practice and that midwives will be held accountable for any errors.

After discussing the insurance issue, legislators asked if the midwives would be open to the requirement that they practice in connection with a physician.²³⁶ In response, the midwives pointed out that a similar provision in the New York law meant that no midwives could practice because no doctors would agree to practice with them.²³⁷ Similar problems arose in California when the state allowed both CNMs and direct-entry midwives to practice and required any midwife of either type to practice under the supervision of a physician.²³⁸ While CNMs were able to find doctors to supervise them, doctors refused to work with direct-entry midwives.²³⁹ Despite these failures, the legislators' interest in having an agreement between direct-entry midwives and physicians should be considered when developing future bills on midwifery in Illinois. The provisions addressing this issue may have to be different than those included in the New York or California bills. For example, even if doctors will not agree to partner with direct-entry midwives, the legislature could still require that hospitals must admit women who have previously been under the care of a midwife. This measure might quell legislators' fears that a woman who chooses a midwife has reached a "point of no return" and will not be able to get the medical care she needs if something goes wrong during the childbirth process.

After three failures in the Regulation and Registration Committee of the House, midwifery advocates attempted to make

²³⁶ *Id.* (statement of Rep. John Fritchey).

²³⁷ *Id.* (statement of Michelle Breen in response to Rep. Fritchey's question).

²³⁸ Tovino, *supra* note 9, at 95.

²³⁹ *See id.*

headway on the issue through the Senate.²⁴⁰ The Coalition for Illinois Midwifery stated that it wanted to begin the discussion of maternity care with a declaration that home births are safe.²⁴¹ The advocates stated once again that hospital deliveries are best for high-risk pregnancies while low-risk deliveries can safely be done at home.²⁴² This bill, which really only declared the scientific conclusion that home birth is safe, passed unanimously in the Senate Committee on State Government.²⁴³ This vote was a “committee message,” meaning that the bill was merely a declaratory statement issued by the committee rather than proposed legislation to be debated on the Senate floor.²⁴⁴ While this bill did not change the legality of direct-entry midwifery in Illinois, it signified an important first step in winning over the senators. Now that the committee has declared that home births are safe, it will be difficult for the medical community to, once again, argue that the Midwifery Model of Care™ is not a safe alternative for women.

In the discussion of the bill in the Illinois Senate, one state senator noted that use of midwives is widespread in the Latino community because many individuals are uninsured²⁴⁵ and hospital births can be prohibitively expensive. Another representative also noted that midwifery is common in rural African American communities.²⁴⁶ These comments indicate that some senators recognize the cultural value and tradition of midwifery and that they are not as hostile to the idea of home births. Perhaps, in the future, Illinois midwifery activists can create partnerships with Latino and African American community groups in order to work together for a direct-entry midwifery bill.

²⁴⁰ See *Midwives: Committee Message S.R. 189 Before the S. Comm. on State Government*, 94th Gen. Assemb. (Ill. 2005) [hereinafter *Committee Message S.R. 189*].

²⁴¹ *Id.*

²⁴² *Id.*

²⁴³ Illinois Legislative Glossary, available at <http://www.ilga.gov/legislation/glossary.asp>.

²⁴⁴ *Id.*

²⁴⁵ *Committee Message S.R. 189*, *supra* note 240.

²⁴⁶ *Id.*

In 2007, midwifery advocates once again proposed a bill in the Illinois Senate which would require midwives to be licensed through the NARM.²⁴⁷ The bill would also have established a disciplinary board made up of midwives, a physician, and a knowledgeable member of the public to regulate direct-entry midwifery.²⁴⁸ In the discussion of the bill, advocates for the bill stated that 800-1000 women birth at home each year in Illinois, but these women have no way to be certain that the midwives attending their births are qualified.²⁴⁹ Framing the issue as one of consumer protection is a wise approach since it changes the debate from a turf war between doctors and midwives into a public safety issue. Thus, doctors can no longer demonize midwifery and are forced to admit that making the practice illegal is not actually protecting the public.

Moreover, in the discussion of the 2007 version of the bill, the midwives included testimonials from citizens who want legalized midwifery.²⁵⁰ For example, representatives of the Health Committee in the Amish Community stated in a letter to the committee that the price of normal delivery in the hospital is prohibitive for their community, and thus, the farmers end up taking jobs away from home just to pay for deliveries.²⁵¹ The Amish representatives stated that they would prefer cheaper alternatives for low-risk pregnancy.²⁵² In the future, advocates for direct-entry midwifery should continue to use testimony from religious communities that actually utilize midwifery in the birth process. Indeed, the stereotype of midwifery advocates is that they are all hippies who reject childbirth in hospitals out of some rebel impulse.²⁵³ Midwifery advocates have noted that stereotypes

²⁴⁷ *Committee Message S.R. 385 Before the S. Comm. on State Government, 95th Gen. Assemb. (Ill. 2007)* [hereinafter *Committee Message S.R. 385*].

²⁴⁸ *Id.*

²⁴⁹ *Hearing on S.B. 385, supra* note 198 (statement of Dan Johnson-Weinberg, Coalition for Illinois Midwifery).

²⁵⁰ *Id.* (statement of Pat Cole, Illinois Families for Midwifery, reading a letter from an Amish Community).

²⁵¹ *Id.*

²⁵² *Id.*

²⁵³ *See* MUHLHAHN, *supra* note 58, at 160.

about feminism and midwifery unfortunately hurt their cause.²⁵⁴ Advocates who take a conservative approach and strongly identify as mothers have tended to be successful.²⁵⁵ Thus, the support of the Amish community in passing a midwifery bill could prove crucial in the future.

During the discussion of the 2007 version of the bill, legislators asked why CNMs could not attend home births rather than legalizing direct-entry midwives to do them.²⁵⁶ A representative from the Coalition for Illinois Midwifery responded that CNMs tended not to practice in the home.²⁵⁷ Opponents of the bill once again argued that the bill would allow “untrained people” to practice medicine.²⁵⁸ And once again this fallacy led to the bill’s failure.²⁵⁹ While, the 2007 version of the bill did pass the Illinois Senate,²⁶⁰ it was unsuccessful in the House.²⁶¹ Passage in one chamber is a landmark in the history of the midwifery movement in Illinois and should be celebrated as an indication that full legalization is possible.

The proposal of the 2009 Homebirth Safety Act, a bill with similar provisions to the 2007 bill, indicated that proponents had wisely chosen to frame it as a consumer protection bill rather

²⁵⁴ See Hoffman, *supra* note 26, at 115–16 (discussing how the midwives in Illinois felt it necessary to point out that the evidence they presented was from peer-reviewed medical journals “not just obscure hippie journals” and then noting that groups in other states felt the need to disassociate themselves from “hippie science” by relying only on credible scientific evidence).

²⁵⁵ See *id.* at 103–04, 118–19 (first describing how activists adapted to the legislative setting by changing their appearance and focus to look more conservative and professional while also advocating based on their authority as women and mothers; then describing how legislators were able to use the rhetoric of motherhood to gain support for the midwife movement and pass legislation).

²⁵⁶ *Hearing on S.B. 385, supra* note 198 (statement of Sen. Ronen).

²⁵⁷ *Id.* (statement of Colette Bernhard, Coalition for Illinois Midwifery).

²⁵⁸ *Id.* (statement of Jim Tierney, Illinois State Medical Society).

²⁵⁹ State of Ill. 95th Gen. Assemb., 1 Legis. Synopsis & Dig. 15, at 349 (2009).

²⁶⁰ Ill. S.B. 385, Third Reading, March 29, 2007 (51 yeas, 7 nays).

²⁶¹ State of Ill. 95th Gen. Assemb., 1 Legis. Synopsis & Dig. 15, at 349 (2009).

than one about the values of obstetrics versus midwifery.²⁶² The 2009 version of the bill also passed in the Senate but failed in the House.²⁶³

E. The Birth Center Legislation Paves the Way for Direct-Entry Midwifery Legislation

Current Illinois law does allow for birthing centers.²⁶⁴ A birthing center is defined as “a designated site that is away from the mother’s usual place of residence and in which births are planned to occur following a normal, uncomplicated, and low-risk pregnancy. A birth center shall offer prenatal care and community education services”²⁶⁵ The statute requires that the birthing center have a “transfer agreement” with a hospital, meaning that if a woman is in distress at the birthing center the hospital agrees to allow her to transfer to its obstetrics unit for further care.²⁶⁶ The statute also requires that the birthing centers be located “within a ground travel time distance from the licensed hospital that allows for an emergency caesarian delivery to be started within thirty minutes of the decision a caesarian delivery is necessary.”²⁶⁷ This ensures that any women or infants whose situation changes rapidly from low-risk to high-risk would be able to quickly have necessary medical care.

The birth centers must be staffed by a physician as the medical director who can be “available on the premises or within a close proximity” and may be staffed with certified nurse-midwives.²⁶⁸ Thus, the women are still birthing with a medical model, and with a physician present, rather than birthing with the Midwifery Model of Care™ advocated by direct-entry midwives. The statute specifies, however, that no general anesthesia

²⁶² See H.R.R. 226, 96th Gen. Assemb. Reg. Sess. (Ill. 2009).

²⁶³ State of Ill. 96th Gen. Assemb., 1 Legis. Synopsis & Dig. 14, at 2321 (2011).

²⁶⁴ 210 ILL. COMP. STAT. 3/35 (2010).

²⁶⁵ *Id.*

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ *Id.*

will be administered at the centers.²⁶⁹ This recognizes that the births need not be treated as potential emergencies or surgeries that require anesthesia. In summary, this statute demonstrates a better understanding of birth as natural and normal for most women, rather than as a dangerous experience requiring intervention.

The implementation of the birth center legislation provides an important example of how the policy debate on direct-entry midwifery in Illinois could proceed. With this legislation, the entire Illinois General Assembly acknowledged for the first time that there is a distinction between high-risk and low-risk pregnancies. While this acknowledgement does not go all the way to the point of recognizing the validity of the Midwifery Model of Care™, it is an important psychological step in acknowledging that births can take place outside of hospitals. Ideally, allowing births in birth centers rather than hospitals is a precursor to allowing home births.

The birth center legislation represented the Illinois State Medical Society's agreement to finally compromise with midwifery advocates. The Illinois State Medical Society agreed to stop opposing the birth centers if the birth centers were located within thirty minutes of a hospital and the midwives agreed to that provision.²⁷⁰ Thus, the compromise that was reached about the birth centers shows that both the legislature and birth advocates are willing to work with the medical community to come to a compromise that is satisfying to both sides. Furthermore, the compromise about the birth centers sets a precedent that the medical community will negotiate if necessary, which makes it harder for the medical community to later dismiss the possibility of negotiations.

²⁶⁹ *Id.*

²⁷⁰ *Birth Center Alternative Health Care Models: Hearings on S.B. 264 Before the H. Human Services Comm.*, 95th Gen. Assemb. (2007) (statement of Rep. Julie Hamos).

IV. THE IMPACT IF MIDWIFERY LEGISLATION WERE PASSED IN ILLINOIS

If midwifery legislation were passed in Illinois, numerous positive benefits would result. Most significantly, of course, women would have a choice in how they would like to birth their babies. Evidence indicates that having this choice would allow Illinois women to be more satisfied with their birthing experience and to undergo fewer unnecessary medical interventions in the childbirth process.²⁷¹ As a result, Illinois women would likely bring fewer lawsuits against obstetricians,²⁷² which would save millions of dollars in litigation costs. Moreover, women who cannot or do not choose expensive healthcare options, particularly Amish women or economically disadvantaged women, could more easily afford childbirth.²⁷³ Furthermore, legalizing midwifery would have limited drawbacks. For low-risk births, home childbirth is as safe as hospital birth.²⁷⁴ After legalization, women who prefer medical childbirth in a hospital could still choose that option and women experiencing high-risk pregnancies would still be transferred to hospitals for childbirth. The cost to Illinois would be minimal because established organizations, like the NARM, would provide the administrative expertise and resources to monitor licensure for direct-entry midwives.²⁷⁵ Thus, the state would be able to allow low-cost, satisfying childbirth to women with minimal administrative costs and no additional health risks. Because of these obvious benefits, Illinois should legalize direct-entry midwifery.

²⁷¹ See Johnson, *supra* note 7, at 1417 (discussing the fact that fewer medical interventions were used in home births and the high satisfaction rates reported by mothers who chose home births); Falker, *supra* note 79, at 24–27.

²⁷² See Falker, *supra* note 79, at 24–27.

²⁷³ See Beckett, *supra* note 27, at 147.

²⁷⁴ See generally Johnson, *supra* note 7; Durand, *supra* note 7.

²⁷⁵ See, e.g., Ill. S.B. 385 (providing that direct-entry midwives would be licensed through the NARM if the bill were passed).

V. CONCLUSION

Illinois stands as one of nine hold-out states that continue to prohibit direct-entry midwifery. In the face of overwhelming evidence that direct-entry midwifery is safe for low-risk pregnancies and is the preference of many women, the Illinois legislature continues to deny women the option of choosing childbirth at home with a midwife. This extreme position is based on the ignorance and fear about home births that the obstetrical lobby continues to foster. As long as the Illinois Medical Association continues to imply that home birth is dangerous and primitive, the Illinois legislature will feel pressured to deny women childbirth choices. In order to combat this pressure, the members of the Illinois General Assembly must first become educated on the Midwifery Model of Care™. Once the legislators understand the facts about home birth, they must consider that they do not represent lobbies or interests, but people. Although the number of people who wish to home birth in Illinois is not the majority, it is a significant minority. There is no logical reason to deny the members of this minority the option to birth at home. Finally, once Illinois legislators understand the facts and their constituents, they must both allow direct-entry midwifery and regulate it. By linking midwifery licensure in Illinois to national certification systems, as other states have done, Illinois legislators can rest assured that the midwifery practiced in the state will be safe.

Doctors, hospital administrators, and insurance companies in Illinois are holding women hostage in a system of care that is not advisable for most births. The Illinois legislature would do well to stop treating the obstetrics lobby as the most important voice in the debate. The best party to decide how a woman should give birth is not an Illinois legislator, or a judge, or the Illinois Medical Association. The best person to decide what is right for a woman's body and a woman's baby is the woman herself.

