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Regulation of Midwives as Home Birth Attendants

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REGULATION OF MIDWIVES AS HOME BIRTH ATTENDANTS

Childbirth practices have become the focus of worldwide debate and controversy among both medical professionals and laypeople.[1] Controversy particularly surrounds the regulation of home births and midwives. Proponents of home birth argue that birth in the home is not only psychologically beneficial to both mother and baby, but also that the home is the safest place to give birth.[2] Midwives, rather than physicians, usually assist home births.[3] Midwives recognize birth as a normal physiological process and avoid unnecessary intervention.[4]

Opponents of home birth argue that it is infinitely more risky, to both mother and baby, to give birth at home.[5] Physicians and obstetricians in the United States traditionally oppose home births. Unlike midwives, they urge that childbirth is inherently dangerous and that technological intervention in a controlled institutional environment can reduce its risk.[6]

Women, the consumers of maternity care, express a desire for more humanized childbirth.[7] Hospital childbirth traditionally shifts power from the mother to her childbirth assistants.[8] Dissatisfaction with hospital births because of this feeling of powerlessness sparked a revival of "natural" childbirth in the 1960s.[9] Today, a significant number of well educated and informed consumers choose planned home births assisted by midwives.[10] Thus, numerous philosophies

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[1] Zander, *Maternity Care An International Perspective*, 31 J. OF NURSE-MIDWIFERY, Sept./Oct. 1986 at 227.

[2] Rantz, *Letter to the Editor*, HASTINGS CENTER REPORT, October 1986 at 43 (discussing article appearing in previous issue). Home birth advocates argue that risks caused by medical professionals and the hospital environment outweigh the risk of limited access to emergency services posed by home births. Hoff & Schneiderman, *Having Babies at Home: Is It Safe? Is It Ethical?*, HASTINGS CENTER REPORT, 21 December 1985 at 19, 21.

[3] *See* Amicus Curiae Brief for the Midwives Alliance of North America at 21–22, Leigh v. Board of Registration in Nursing, 395 Mass. 670, 481 N.E.2d 1347 (1985) (No. 3857). [hereinafter MANA BRIEF].

[4] Zander, *supra* note 1, at 230.

[5] Hoff & Schneiderman, *supra* note 2, at 19.

[6] Zander, *supra* note 1, at 228, 230.

[7] *See* J. LITOFF, THE AMERICAN MIDWIFE DEBATE 13–14 (1986); Hoff & Schneiderman, *supra* note 2, at 22.

[8] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 13–14.

[9] *Id.*

[10] MANA BRIEF, *supra* note 3, at 21.

and perspectives compete in the debate over midwives and home birth.

The competing philosophies in the debate over midwives and home birth originate, in part, in the history of midwifery. In America, the term midwife summons images ranging from the superstitious, ignorant peasant woman of medieval times to the trained, highly skilled professionals found in Great Britain and other countries in western Europe.[11] For centuries midwifery remained exclusively a female domain.[12] Childbearing and assisting at birth were considered by most members of society to be the necessary and unavoidable duties of women.[13] In England during the eighteenth century, however, men started displacing women from their roles as birth attendants. This trend resulted from significant advances in British, male-dominated medicine which promised safer childbirth.[14] Following the British trend, male physicians almost completely replaced midwives at the deliveries of upper-class and middle-class urban women in America by the early nineteenth century.[15] Throughout this period, critics unsuccessfully attempted to reclaim obstetrics for the midwives.[16]

Physicians now attend the deliveries of the vast majority of all classes of women in the United States.[17] Additionally, physicians traditionally oppose home births, arguing that home births are unsafe.[18] Because physicians attend the majority of births and traditionally oppose home births,[19] over ninety-nine percent of all births in 1970 occurred in an institutional setting.[20]

While physicians continue attending the majority of births, the number of births attended by midwives increased significantly be-

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[11] J. DONEGAN, WOMEN & MEN MIDWIVES 3 (1978).

[12] *Id.* at 9.

[13] *Id.*

[14] *Id.* at 4.

[15] *Id.*

[16] *Id.* at 5.

[17] TAFFEL, VITAL AND HEALTH STATISTICS U.S. DEPT. OF HEALTH AND HUMAN SERVICES, PUB. NO. (PHS) 84-1918, SERIES 21, NO. 40 MIDWIFE AND OUT-OF-HOSPITAL DELIVERIES, UNITED STATES 17 (1984). [hereinafter STATISTICS] By 1910 midwives attended approximately fifty percent of all births in the United States. J. LITOFF, AMERICAN MIDWIVES 1860 TO THE PRESENT 27 (1978). This figure includes home and hospital births. This figure declined to 0.9 percent of all births by 1975 (0.6 at hospital, 0.3 not at hospital). STATISTICS, *supra*, at 17.

[18] Zander, *supra* note 1, at 228, 230.

[19] *See supra* note 6 and accompanying text.

[20] STATISTICS, *supra* note 17, at 4. The majority of births in the United States occurred at home until about 1940. *Id.* Home births declined tremendously from this level to a low of 0.6 percent of all births in 1970. *Id.*

tween 1975 and 1979.[21] Today health care consumers choose midwifery with increasing frequency. Because midwives, rather than physicians, usually assist home births[22] and the number of births attended by midwives increased, the number of nonhospital births correspondingly increased during the 1970s.[23]

The historic trend away from home births derives mainly from the argument that a hospital birth is a safer birth.[24] The evidence to support this argument, however, is inconclusive.[25] Some studies indicate that the perinatal mortality rate is six times greater for hospital births as compared to home births.[26] The results of these studies conflict with the results of other studies which the American College of Obstetricians and Gynecologists (ACOG) has used to show that home births are four times more dangerous than hospital births.[27] In April, 1985, the World Health Organization recognized the ambiguity of available studies and recommended joint surveys between countries to evaluate childbirth methodologies.[28] Thus, the safety issues of home birth are far from clearcut and much research still is needed.

Perhaps because the safety of home births is unclear, the fifty states and the District of Columbia correspondingly have never treated or regulated midwifery uniformly. A midwife may be either a nurse-midwife or a lay midwife. Nurse-midwives are trained and regulated as nurses.[29] States usually require separate certification or licensure for nurses to practice as nurse-midwives,[30] and generally provide standards and regulations for nurse-midwives which are in addition to those required of nurses.[31] Nurse-midwives most usually assist births in an institutional setting,[32] but may assist home births.[33]

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[21] *Id.* at 17. In 1979, midwives attended 1.6 percent of all births in the United States. *Id.* This represents a 77.8 percent increase in midwife attended births over the 1975 figure.

[22] *See supra* note 3 and accompanying text.

[23] STATISTICS, *supra* note 17, at 4. Since 1970, home births have risen to one percent of all births in 1979. *Id.*

[24] Zander, *supra* note 1, at 231.

[25] *Id.*

[26] *Id.*

[27] *Id.*

[28] *Appropriate Technology for Birth*, 1985 LANCET 436 .

[29] R. DEVRIES, REGULATING BIRTH: MIDWIVES, MEDICINE & THE LAW 17 (1985).

[30] *See* DEVRIES, REGULATING, *supra* note 29, at 17.

[31] *See id.*

[32] *See infra* notes 139–43 and accompanying text.

[33] *See infra* note 144 and accompanying text.

Lay midwives may be licensed nurses[34] or non-nurse lay people.[35] They may receive fairly extensive formal training and education or, alternatively, be completely self-educated.[36] Lay midwives usually practice professionally and charge for their services.[37] They almost exclusively assist home births.[38]

Regulation of nurse-midwives and lay midwives varies from state to state. All fifty states and the District of Columbia permit the practice of nurse-midwifery.[39] Twenty-three states expressly approve the practice of lay midwifery.[40] Of the states which regulate

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[34] *See, e.g.*, Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476 (Tenn. Ct. App. 1980); Leigh v. Board of Registration in Nursing, 399 Mass. 558, 506 N.E.2d 91 (1987) (*Leigh II*).

[35] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 14–15; DEVRIES, REGULATING, *supra* note 29, at 17.

[36] *Id.*

[37] *See id.*

[38] *See* LITOFF, MIDWIVES 1860, *supra* note 17, at 143–44.

[39] *See* ALA. CODE §§ 34-19-2–34-19-10 (1985); ALASKA STAT. §§ 08.68.010–08.68.410 (1987); ARIZ. REV. STAT. ANN. § 336-752.2 (1956); ARK. STAT. ANN. §§ 17-86-501–17-86-507 (1987); CAL. BUS. & PROF. CODE §§ 2746–2746.8 (West Supp. 1988); COLO. REV. STAT. § 12-36-106(1)(f) (1985); CONN. GEN. STAT. §§ 20-86a–20-102a (Supp. 1987); DEL. CODE ANN. tit. 16, § 122(3)(h) (1974 & Supp.1986); D.C. CODE ANN. §§ 2-3306.1–3306.8 (Supp. 1987); FLA. STAT. ANN. §§ 464.001–464.023 (West 1981 & Supp. 1987); GA. CODE ANN. §§ 43-26-1–43-26-39 (1984); HAW. REV. STAT. § 321-13 (1985); IDAHO CODE §§ 54-1401–54-1416 (1979 & Supp. 1987); ILL. ANN. STAT. ch. 111, para. 3401–3437 (Smith-Hurd 1978 & Supp. 1987); IND. CODE ANN. § 25-22.5 (Burns 1982 & Supp. 1987); IOWA CODE ANN. §§ 152.1–152.10 (West 1972 & Supp. 1987); KAN. STAT. ANN. §§ 65-1113–65-1134 (1985); KY. REV. STAT. ANN. §§ 314.011–314.991 (Michie/Gobbs-Merrill 1983 & Supp. 1986); LA. REV. STAT. ANN. §§ 37:911–37:931 (West 1974 & Supp. 1987); ME. REV. STAT. ANN. tit. 32, §§ 2101–2258 (1978 & Supp. 1986); MD. HEALTH OCC. CODE ANN. §§ 7-601–7-603 (1986); MASS. GEN. L. ch. 112, §§ 74–81C (1986); 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.); MICH. STAT. ANN. § 14.15(17210) (Callaghan 1980); MINN. STAT. §§ 148.171–148.285 (1980); MISS. CODE ANN. §§ 73-15-1–73-15-37 (1972 & Supp. 1987); MO. ANN. STAT. § 335 (Vernon 1966 & Supp. 1988); MONT. CODE ANN. §§ 37-8-101–37-8-444 (1987); NEB. REV. STAT. §§ 71-1738–71-1765 (1986); NEV. REV. STAT. ANN. § 632 (Michie 1986 & Supp. 1987); N.H. REV. STAT. ANN. § 326-B (1984 & Supp. 1987); N.J. STAT. ANN. § 45:10 (West 1978 & Supp. 1987); N.M. STAT. ANN. §§ 9-7-6, 24-1-3(R), 24-1-21, 61-6-16 (1978); N.Y. PUB. HEALTH LAW § 2560 (McKinney 1985); N.C. GEN STAT. §§ 90-178.1–90-178.7 (1985); N.D. CENT. CODE § 43-12.1 (1978 & Supp. 1987); OHIO REV. CODE ANN. §§ 4731.30, 4731.32, 4731.33 (Baldwin 1984 & Supp. 1987); OKLA. STAT. ANN. tit. 59, §§ 577.1–577.6 (West Supp. 1988); OR. REV. STAT. § 678 (1987); PA. STAT. ANN. tit. 63, §§ 171–176 (Purdon 1968); R.I. GEN. LAWS §§ 23-13-9–23-13-10 (1956); S.C. CODE ANN. § 40-33 (Law. Co-op. 1986 & Supp. 1987); S.D. CODIFIED LAWS ANN. § 36-9A (1986); TENN. CODE ANN. §§ 63-7-101–63-7-209 (1986); TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp.1988); UTAH CODE ANN. § 58-44 (1986 & Supp. 1987); VT. STAT. ANN. tit. 26, §§ 1571–1584 (Supp. 1987); VA. CODE ANN. § 54-274 (1982 & Supp. 1987); WASH. REV. CODE ANN. § 18.88 (1978 & Supp. 1987); W. VA. CODE §§ 30-15-1–30-15-8 (1986); WIS. STAT. ANN. § 441.15 (West 1988); WYO. STAT. ANN. §§ 33-21-101–33-21-156 (Michie 1987). *See generally* Mullinax, *Supplemental Report on Nurse-Midwifery Legislation*, 32 J. OF NURSE-MIDWIFERY 156–180, 222–253 (1987).

[40] *See* ALA. CODE § 34-19-3(b) (1985); ALASKA STAT. §§ 18.05.056–18.05.070 (1986); ARIZ. REV. STAT. ANN. §§ 36-751–36-757 (1965 & Supp. 1987); ARK. STAT. ANN. §§ 17-85-101–17-

the practice of nurse-midwifery, two states explicitly restrict a nurse-midwife's attendance at home births.[41]

The regulatory schemes of Wisconsin, Tennessee, Massachusetts, and Texas exemplify the inconsistent regulation of midwifery in the United States. Wisconsin, Tennessee, and Massachusetts regulate nurse-midwifery but do not prohibit or regulate lay midwifery.[42] Wisconsin explicitly prohibits nurse-midwives from attending home births.[43] While Tennessee does not prohibit nurse-midwives from attending home births by statute,[44] Tennessee case law indicates that nurse-midwives may not attend home births.[45] Massachusetts amended its nurse-midwifery statute in 1987 to allow the attendance of nurse-midwives at home births.[46]

In contrast to Wisconsin, Tennessee, and Massachusetts, Texas comprehensively regulates both nurse-midwifery and lay midwifery.[47] Furthermore, Texas allows nurse-midwives and lay midwives to attend home births.[48] Thus, Wisconsin, Tennessee, Massachusetts, and Texas approach the regulation of midwifery very differently.

Restricting the attendance of nurse-midwives at home births while at the same time allowing the attendance of lay midwives creates potentially three classifications: the nurse-midwife, who may

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85-108 (1987 & Supp. 1987); CAL. BUS. & PROF. CODE §§ 2505–2515 (West Supp. 1988); FLA. STAT. ANN. § 467 (West Supp. 1987); GA. CODE ANN. § 31-26 (1985); ILL. ANN. STAT. ch. 111, para. 4411-3 (Smith-Hurd 1978 & Supp. 1987); LA. REV. STAT. ANN. § 37:1277 (West Supp. 1987); MICH. STAT. ANN. § 14.15(17001) n.24 (Callaghan 1980); MINN. STAT. §§ 148.30–148.32 (1980); MISS. CODE ANN. § 73-25-35 (1972 & Supp. 1987); MO. ANN. STAT. §§ 334.190, 334.260 (Vernon 1966); N.H. REV. STAT. ANN. § 326-D (1984); N.J. STAT. ANN. § 45:10 (West 1978 & Supp. 1987); N.M. STAT. ANN. §§ 24-1-3(R), 61-6-16(C) (1978); N.C. GEN. STAT. § 90-178.1–90-178.7 (1985); R.I. GEN. LAWS § 23-13-9 (1956); S.C. CODE ANN. § 40-33-50(7) (Law. Co-op.); TENN. CODE ANN. § 63-6-204 (1986); TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988); VA. CODE ANN. §§ 32.1-145–32.1-147 (1982); WASH. REV. CODE ANN. § 18.50 (1978 & Supp. 1987); WIS. STAT. ANN. § 448.10(5) (West 1988). *See generally* Mullinax, *Supplemental Report on Nurse-Midwifery Legislation*, 32 J. OF NURSE-MIDWIFERY 156–180, 222–253 (1987).

[41] ALA. CODE § 34-19.8 (1985); WIS. STAT. ANN. § 441.15(2)(b) (West 1988). Lay midwives primarily assist home births.

[42] *See* MASS. GEN. L. ch. 112, §§ 74–81C (1986); TENN. CODE ANN. §§ 63-7-101–63-7-209 (1986); WIS. STAT. ANN. § 441.15 (West 1988). *See generally* Mullinax, *Supplemental Report on Nurse-Midwifery Legislation*, 32 J. OF NURSE-MIDWIFERY 156–180, 222–253 (1987).

[43] *See* WIS. STAT. ANN. § 441.15(2)(b) (West 1988).

[44] *See* TENN. CODE ANN. §§ 63-7-101–63-7-209 (1986).

[45] *See* Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 481 (Tenn. Ct. App. 1980).

[46] 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.).

[47] TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

[48] *Id.*

not attend home births; the lay midwife, who may attend home births; and the nurse functioning as a lay midwife, whose legal ability to attend home births may be unclear. Under the equal protection clause of the fourteenth amendment to the United States Constitution, a classification discriminating between lay midwives who are nurses and lay midwives who are not nurses must be reasonably related to a permissible state purpose.[49]

In Massachusetts, a midwife unsuccessfully claimed that suspending her nursing license because she practiced lay midwifery violated the equal protection clause of the fourteenth amendment. In *Leigh v. Board of Registration in Nursing*,[50] the midwife, Leigh, argued that applying nurse-midwifery regulations to a nurse practicing as a lay midwife created two classifications of lay midwives: lay midwives who are not nurses and lay midwives who are nurses.[51] Leigh took the position that discriminating between these two classifications of lay midwives did not further a legitimate state interest.[52] The court did not address the two classifications of lay midwives but instead addressed the distinctions between lay midwives and nurse-midwives. The court held that suspension of Leigh's nursing license for the practice of lay midwifery was permissible constitutionally.[53] Thus, while midwifery regulations may create classifications of midwives, the only court addressing this issue concluded that such classifications do not violate the equal protection clause of the fourteenth amendment.

This note analyzes the classification of lay midwives into nurses and non-nurses under the equal protection clause of the fourteenth amendment to the United States Constitution. Section I will examine midwifery as a profession, first placing present-day midwifery in its historical context,[54] then exploring the relative safety and efficacy of various childbirth choices.[55] Section II will examine how state legislatures address regulation of midwifery, focusing in particular on regulation in Wisconsin, Tennessee, Massachusetts, and

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[49] *See* Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560, 506 N.E.2d 91, 93 (1987) (*Leigh II*); U.S. CONST. amend. XIV, § 1. "[N]or shall any State . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

[50] *Id.*

[51] Brief for Appellant at 30, Leigh v. Board of Registration in Nursing, 399 Mass. 558, 506 N.E.2d 91 (1987) (No. 4173).

[52] *Id.* at 28–40.

[53] *Leigh II*, 399 Mass. at 560, 506 N.E.2d at 93.

[54] *See infra* notes 71–146 and accompanying text.

[55] *See infra* notes 147–73 and accompanying text.

Texas.[56] This section then will present the standard of review that the United States Supreme Court has applied to laws regulating professions under the equal protection clause of the fourteenth amendment.[57] Finally, this section will introduce the cases from Tennessee and Massachusetts in which nursing boards suspended a nurse's license because the nurse practiced lay midwifery.[58]

Although finding that the Wisconsin, Tennessee, and Massachusetts regulatory schemes pass constitutional scrutiny,[59] Section III will argue that these statutes are not the best way to protect the health and safety of citizens in these states.[60] This section will present the Texas regulatory scheme for midwifery as a model for other states in regulating midwifery.[61] This note will advocate that, although classifications made between lay midwives who are nurses and those lay midwives who are not nurses probably pass constitutional muster, state legislatures could better protect the well-being of mothers and infants first by regulating lay midwifery,[62] second by allowing a nurse the choice to function as a lay midwife instead of a nurse-midwife,[63] and third by permitting nurse-midwives to attend home births.[64]

I. MIDWIFERY

To place the present regulation of midwives in the United States in context, this section will examine the historical trends[65] in childbirth and the relative safety of childbirth choices.[66] Midwives traditionally attended the majority of births.[67] As physicians entered the area of childbirth promising greater safety,[68] the number of midwives correspondingly decreased.[69] Medical research, however, does not strongly support the assumption that physicians are invar-

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[56] *See infra* notes 174–221 and accompanying text.
[57] *See infra* notes 222–49 and accompanying text.
[58] *See infra* notes 250–289 and accompanying text.
[59] *See infra* notes 309–28 and accompanying text.
[60] *See infra* notes 329–37 and accompanying text.
[61] *See infra* notes 338 and accompanying text.
[62] *See infra* note 329 and accompanying text.
[63] *See infra* notes 330–333 and accompanying text.
[64] *See infra* note 340 and accompanying text.
[65] *See infra* notes 71–146 and accompanying text.
[66] *See infra* notes 147–173 and accompanying text.
[67] *See infra* note 77 and accompanying text.
[68] *See infra* notes 97–99, 118–22 and accompanying text.
[69] *See infra* notes 100–103, 109–12, 123–26 and accompanying text.

iably the safest birth attendants or that home births are unquestionably unsafe.[70]

A. *History of Childbirth Attendants*

Midwifery, historically a female profession, has progressed from a group of unorganized, untrained, and unregulated birth attendants[71] to a group of organized, generally trained, and increasingly regulated birth attendants.[72] In the United States, midwives attended the majority of births until early in this century.[73] Between 1910 and 1975, the number of births attended by midwives decreased to less than one percent of all births.[74] In the 1950s, midwives organized and sought recognition as trained, professional

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[70] *See infra* notes 147–173 and accompanying text.

[71] *See generally* J. TOWLER & J. BRAMALL, MIDWIVES IN HISTORY AND SOCIETY (1986). The midwives of the eleventh century period were most likely illiterate and uneducated with some possessing practical knowledge and skills while others were probably both ignorant and unproficient. *Id.* at 22.

Midwives of this period clearly were tried as witches. T. FORBES, THE MIDWIFE AND THE WITCH 117 (1966). Witch hunting, trials and burnings were commonplace. Poor people and women had no influence or power in this Church-dominated society. Some sought witchcraft possibly as a source of potential power. The use of witchcraft by the poor peasants, especially *women* peasants, presented a threat to the influence of the Church. TOWLER, *supra*, at 34.

Witchcraft related to many of the superstitions surrounding birth. Additionally, witches needed the by-products of birth and fetal parts for ceremonial purposes. FORBES, *supra*, at 118. The fat of unbaptized infants formed the base for the "ointment of witches" used to induce an altered state of mind during witchcraft ceremonies. *Id.* at 119.

Many of the charges were untrue and prosecutors often obtained "confessions" under duress. *Id.* at 115. Alongside the admitted and organized witches were community women practicing herbal medicine — the midwives, wise women and healers. While their motives were credible, the Church classified them as witches. Eventually these women were distinguished from organized witches as "whitewitch[es]" or "blessing witch[es]." TOWLER, *supra*, at 34–35.

During the fifteenth, sixteenth and part of the seventeenth centuries, midwifery was on the whole a lowly profession. FORBES, *supra*, at 112. In France, the fees paid midwives were so incredibly small that they left midwives economically worse off than other peasants. In Bavaria, a midwife's social standing was so inferior that she was scorned by even the lowest male occupation. Her son might be barred from a trade guild because of her profession. *Id.* at 112–13.

Although medicine was beginning to be based on scientific knowledge, midwifery had no such scientific basis. Because of the lack of teachers and education, midwives received limited formal instruction leaving them frequently ignorant and superstitious. *Id.* at 112. Midwives generally had no detailed knowledge of a mother's pregnancy prior to the actual delivery. They used no equipment. Most importantly, they lacked even the most basic theoretical knowledge of anatomy and physiology because of their exclusion from education. TOWLER, *supra*, at 44.

[72] DEVRIES, REGULATING, *supra* note 29, at 17–18.

[73] LITOFF, MIDWIVES 1860, *supra* note 17, at 17.

[74] STATISTICS, *supra* note 17, at 17.

birth attendants.[75] Since 1950, legislatures have enacted regulatory schemes for nurse-midwives and, to a lesser degree, lay midwives.[76] Thus, midwives gradually have organized and achieved recognition.

The history of midwifery demonstrates that although assisting in childbirth was exclusively a female domain for centuries,[77] male physicians have attempted to replace midwives as the primary birth attendants.[78] Men entered the field of childbirth during the six-

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[75] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 12–13.

[76] *Id.* at 16–17.

[77] DONEGAN, *supra* note 11, at 9.

[78] *See* TOWLER, *supra* note 71, at 12. Around 500 B.C., Greek midwives were an honored group of practitioners and given social recognition. At the time of Hippocrates and Socrates, midwives were divided into two classes. Midwives possessing superior skill and experience assisted with abnormal and/or difficult labors. Less experienced midwives attended normal births. Additionally, male and female physicians were available if needed. *Id.*

By 300 B.C., midwives had experienced a drastic change in their social status. *Id.* at 13. The change in the status of midwives was associated with changes in attitudes to women as healers and midwives. In Athens, women were prohibited from practicing midwifery. *Id.*

During this period, the greek midwife Agnodike was tried for practicing midwifery under "false pretenses." Agnodike disguised herself as a man and studied midwifery under a male physician. She then practiced midwifery disguised as a male but revealed her true sex to her patients. Agnodike's services were in great demand amongst the women of Athens. Needless to say, this adversely affected the livelihood of male physicians who denounced her and brought charges for illegal practice of midwifery. The women of Athens appealed for clemency for Agnodike. The lawyers repealed the Athenian Law prohibiting women from practicing midwifery and provided that "three of the sex should practice this art in Athens." *Id.* at 13–14.

During the thirteenth century, men studied medicine at secular universities. *Id.* at 29, 50. Male physicians became an elitist group as a result of the monetary cost and time involved in receiving the required university training. DONEGAN, *supra* note 11, at 14. Society excluded women from universities in England and higher education generally was unavailable to women in other parts of Europe. TOWLER, *supra* note 71, at 29. Because society denied women the necessary education and training to practice medicine, the medical profession also excluded them from participating in the formalizing and organization of medicine. *Id.* at 28–29.

In addition to physicians, practitioners were organizing two other professional groups within medicine, surgeons and apothecaries. Surgeons were less prestigious than physicians and were organized into Barber-Surgeon's Guilds during the thirteenth century. *Id.* Very few women were admitted to these guilds. Barbers were a class of surgeons who were tradesmen skilled with instruments and performed minor surgery. Their role in childbirth was to remove the baby (usually dead) with instruments. Because barbers possessed the exclusive rights to use instruments, midwives were barred from using instruments at a birth and were forced to call a barber-surgeon if instruments became necessary. Surgeons received more extensive training and performed major surgery. *Id.*

As a result of their exclusion from educational facilities, the profession of medicine evolved actually to disqualify women, the very individuals who had previously been the unofficial practitioners of daily medicine. *Id.* at 29. Interestingly, early male physicians showed no interest in women's conditions or midwifery. As a result, women continued to attend childbirth. *Id.*

teenth century.[79] The interest in childbirth on the part of male physicians began the process resulting in compulsory training and regulation of midwives.[80] Physicians in Germany, Holland, Switzerland, and France encouraged municipal authorities to organize and to regulate the practice of midwifery.[81]

Both the Church and the State first regulated midwifery in England during the sixteenth and seventeenth centuries.[82] In the middle sixteenth century the episcopacy started to license midwives.[83] Under their requirements, first a midwife had to show that she was professionally competent[84] and had received proper instruction in baptism.[85] Next licensed midwives and surgeons examined the midwife regarding her character and skill.[86] Lastly, the regulation required the midwife to take an oath which specified that she would not practice witchcraft.[87] Midwives practicing without a li-

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[79] TOWLER, *supra* note 71, at 43.

[80] *Id.* Ultimately, this process also led to the role conflict between physicians and midwives that still exists today. *Id.* The new learning available to men widened the gap between physician and midwife and reinforced male supremacy in the medical arena. *Id.* at 45. *See generally* W. ARNEY, POWER AND THE PROFESSION OF OBSTETRICS 20–50 (1982).

[81] *Id.* at 50.

[82] FORBES, *supra* note 71, at 139–43. Regulation of midwifery began somewhat earlier in Germany and France. The first municipal ordinances are thought to be those in the *Hebammenordnung* of Regensburg, Germany, dating from 1452. *Id.* at 131–32. The first German ecclesiastical regulations seem to be the Würzburg Synodal Statutes of 1491. These German regulations in part dealt with midwifery training, service of rich and poor, and when the midwife should seek medical assistance. *Id.* Also evident was concern that midwives might engage in witchcraft or superstitious methods. *Id.* French regulations similarly recognized the need for close supervision of the midwife, mandated that they receive professional and religious instruction, and required that they take an oath. *Id.*

[83] *Id.* at 143. In 1512, under Henry VIII, Parliament passed an act which allowed the Church to issue licenses for the practice of medicine and surgery. Licensing of qualified midwives probably began shortly thereafter. *Id.*

[84] *Id.* at 144; DONEGAN, *supra* note 11, at 11. During the seventeenth century, as is the case now, most births were uncomplicated. Childbirth was not yet believed to be inherently dangerous or traumatic. Midwives were to permit birth to occur with little or no interference. *Id.* at 10. Testimonials indicate that midwives gained experience by practicing midwifery unlicensed for years. It is doubtful that they were always, or even often, supervised. *Id.* at 13.

[85] FORBES, *supra* note 71, at 144. The Church was very concerned that midwives be able to baptize infants who might not survive until a priest could be summoned. DONEGAN, *supra* note 11, at 11.

[86] FORBES, *supra* note 71, at 144. English regulations were most concerned initially with the character of the midwife as opposed to her obstetrical skill. *Id.* at 139. The ideal qualifications of the midwife were that she be a "paragon of virtue, a source of comfort and support to the woman in labor." DONEGAN, *supra* note 11, at 11.

[87] DONEGAN, *supra* note 11, at 11–12; FORBES, *supra* note 71, at 144.

cense, or violating rules of professional conduct, could be charged and brought to trial before an ecclesiastical court.[88]

During the eighteenth century, British medicine progressed significantly.[89] Physicians entered the field of childbirth promising greater safety for women and their infants.[90] Although the Royal College of Physicians officially recognized midwifery as a form of medical practice for its members,[91] it did not regulate midwives.[92] Physicians replaced midwives in increasing numbers, replacing midwives almost completely by the early nineteenth century.[93]

Similar to their British counterparts of the seventeenth century, midwives played a major role in childbirth in colonial America.[94] While most midwives held a respected position in early America, some continued to be prosecuted as witches.[95] Midwives were subject to very little regulation, as were other medical professionals. Society viewed birth as a normal process requiring little human intervention.[96]

Although midwives initially held a respected position in American society, male physicians started replacing midwives as birth attendants during the eighteenth century.[97] By the end of the eighteenth century, the United States had four male-only medical schools. The scientific education these schools made available to males interested in obstetrics gave them a tremendous advantage over female midwives. Midwives experienced increasing difficulty remaining up to date with obstetrical advances.[98] Throughout this period, midwives and their supporters unsuccessfully attempted to restore obstetrics to the midwives.[99]

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[88] FORBES, *supra* note 71, at 149.

[89] DONEGAN, *supra* note 11, at 4. From this point on, this history will focus on only the evolution of British and American midwives.

[90] *Id.*

[91] *Id.* at 13.

[92] *Id.* Additionally, the two other organized groups of medical practitioners did not regulate midwives. *Id.* See *supra* note 78 for a discussion of organized groups of medical professionals.

[93] DONEGAN, *supra* note 11, at 4.

[94] LITOFF, MIDWIVES 1860, *supra* note 17, at 4.

[95] *Id.* at 4–5. In 1638 magistrates of New England prohibited Jane Hawkins, a midwife, from practicing medicine after she delivered a stillborn infant and was accused of witchcraft. *Id.*

[96] *Id.* at 5.

[97] *Id.* at 9.

[98] *Id.*

[99] DONEGAN, *supra* note 11, at 5.

By the 1860s, male obstetricians had replaced midwives almost completely in their attendance on upper-class and middle-class women for childbirth.[100] In 1868, physicians founded the *American Journal of Obstetrics* as the first specialized medical journal in the United States.[101] They established the American Gynecological Society and the American Association of Obstetricians and Gynecologists in 1876 and 1888, respectively.[102] Physicians urged that only physicians were qualified to engage in obstetrics, a complex medical specialty. The medical profession viewed childbirth as an abnormal condition, which it necessarily had to control with drugs, instruments, and surgery.[103]

Regulation of physicians as health care professionals in the United States began in the nineteenth century and improved the credibility of physicians as childbirth attendants.[104] The American Medical Association (AMA) actively pursued licensure of physicians at the state level shortly following its inception in 1847.[105] Licensure of physicians established the legal precedent for licensure of health care professionals and provided a political model to achieve licensure.[106] The implications for other health care professionals reached further than providing a political model for licensure, however. The timely licensure of physicians gave physicians unique and exclusive status among health care professionals.[107] Other health care professionals found it necessary either to avoid areas of practice already reserved to physicians or to prepare for tremendous opposition if they infringed on these areas.[108]

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[100] *Id.* at 4.

[101] LITOFF, MIDWIVES 1860, *supra* note 17, at 20–21. Physicians generally ignored midwives during the late nineteenth century and assumed that physicians eventually would replace midwives entirely.

[102] *Id.*

[103] *Id.*

[104] *See Id.* at 18–21.

[105] Bullough, *The Current Phase In The Development of Nurse Practice Acts*, 28 ST. LOUIS U.L.J. 365 (1984). The American Medical Association felt that licensure would help it achieve its objectives of 1) raising the level of physician competence, 2) raising educational standards, 3) decreasing competition from other types of practitioners, and 4) increasing the status and power of physicians. The AMA organized state and local medical societies to pursue licensure. In 1873, Texas passed the first major act requiring state examinations and registration for physicians. *Id.*

[106] *Id.* at 366.

[107] *Id.* The authors and revisors of physician registration acts assumed that physicians were the only health care professionals. *Id.*

[108] *Id.* Until the early 1970s, nursing professionals avoided areas of practice already reserved to physicians. *Id.* Since 1971, the nursing profession has been expanding into areas of practice which were once exclusively part of the physician's domain. *Id.*

Despite the increased prestige of physicians resulting from licensure, midwives continued to deliver approximately fifty percent of all infants during the first decade of the twentieth century.[109] While physicians attended most upper-class and middle-class deliveries, midwives attended the majority of rural deliveries and deliveries of poorer women.[110] Women chose midwives, in part, because midwives' fees were one-third to one-half those of physicians, and midwives provided nursing and housekeeper services after the delivery.[111] Additionally, women avoided hospital births because of their cost and because society, in general, viewed hospitals as disease-ridden places for death.[112] Consequently, the vast majority of all births took place in the home.

At the turn of the century very few states regulated midwifery and satisfactory training programs virtually did not exist.[113] Although a few American schools provided satisfactory training programs,[114] only a very small number of midwives received training at such schools.[115] Thus, with the exception of some midwives who received excellent training,[116] the majority of midwives lacked formal training and were ignorant of modern obstetrical techniques.[117]

By 1910, physicians, health officials, and legislators no longer ignored midwifery but, in contrast, hotly debated the role midwives should play in healthcare.[118] Physicians were concerned with the overabundance of medical practitioners and with medical education reform. Many physicians believed that eliminating midwifery would decrease competition for physicians.[119] Additionally, around 1910, health officials became aware of the excessively high maternal and

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[109] LITOFF, MIDWIVES 1860, *supra* note 17, at 27. Immigrant women and Southern black women indicated a definite preference for midwives. *Id.*

[110] *See* DONEGAN, *supra* note 11, at 4.

[111] LITOFF, MIDWIVES 1860, *supra* note 17, at 28. Physicians clearly did not perform these services. *Id.*

[112] *Id.*

[113] *Id.* at 29, 32. A few schools for midwives did exist but the quality of the instruction these schools offered is highly questionable. *Id.* at 32–33.

[114] *Id.* at 34–35.

[115] *Id.* at 41.

[116] *Id.* at 33–34. A number of European immigrants were midwives who had been trained at European schools. Mormon midwives generally were well trained. *Id.*

[117] *Id.* at 41.

[118] *Id.*

[119] *Id.* at 48. Physicians were concerned that the increasing number of physicians would decrease both their status and their incomes. Physicians used state regulation to help limit their own numbers. Physicians also limited the number of medical schools and graduates. The American Medical Association began to police the quality of medical schools in 1906 and pursue medical education reform. *Id.* at 48–50.

infant mortality rates in the United States. Physicians and health officials questioned the influence midwives had on these statistics.[120] The "midwifery problem" received considerable debate.[121] States addressed midwifery by actively regulating midwives or by completely outlawing midwifery.[122]

As a result of pressure from physicians and new legislation, by 1930 midwives attended only fifteen percent of all births.[123] Several factors contributed to the decrease in the number of midwives in the United States. First, physicians strongly urged that only physician intervention would lower childbirth death rates.[124] Second, the superior organization and political power that opponents of midwifery possessed allowed them to influence state legislatures to appropriate inadequate funds for training and regulation of midwives,[125] and to enact state regulation which decreased the number of midwives eligible to practice midwifery.[126]

During the midwife debate of the early twentieth century, some physicians and health officials endorsed the idea of a trained and regulated nurse-midwife as an answer to the "midwife problem."[127] The nurse-midwife is a licensed nurse with additional training in obstetrics.[128] During the 1920s and 1930s, midwifery supporters established schools for nurse-midwifery and employed their graduates. Supporters of midwifery gradually continued to form additional programs.[129]

In 1955, nurse-midwives took charge of their profession by forming the American College of Nurse-Midwives (ACNM) in order to evaluate nurse-midwifery education programs and achieve legal

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[120] *Id.* at 50–51. In 1917, the United States Children's Bureau reported that childbirth was responsible for more deaths among women of childbearing age than any disease except tuberculosis. Of the fifteen countries studied, only two had maternal mortality rates higher than the United States. *Id.* at 53.

[121] *Id.* at 137.

[122] *Id.* at 137–39.

[123] *Id.* at 139.

[124] *Id.*

[125] *Id.* at 140.

[126] *Id.* at 141. Lastly, social and cultural changes tended to support hospital births and the use of obstetricians. The number of hospital beds available for maternity use increased. The automobile allowed easy transportation to the hospital. A significant drop in the birth rate caused an increasing number of people to view birth as a special event requiring a physician's skill. *Id.* at 141–42.

[127] *Id.* at 142.

[128] *Id.*

[129] *Id.* A nurse-midwife is a registered nurse with an additional one to two years of obstetrical training. DEVRIES, REGULATING, *supra* note 29, at 17.

recognition of the nurse-midwife.[130] In the last two decades, the status of the nurse-midwife has improved significantly.[131] In 1971, the American College of Obstetricians and Gynecologists formally recognized the nurse-midwife as part of the obstetric team.[132]

During the 1970s, interest in lay midwifery experienced a revival. Organizations, critical of the automatic and impersonal approach to childbirth practiced in many American hospitals, promoted family-centered obstetrical care and home birth.[133] Individuals interested in home birth turned to lay midwives to be their birth attendants.[134]

Unlike midwives at the turn of the century, the majority of today's lay midwives are both educated and organized.[135] They primarily assist home births.[136] Present-day lay midwives may be licensed nurses or non-nurse lay people.[137] They may receive fairly extensive formal training and education or, alternatively, they may be completely self-educated.[138]

The American College of Nurse-Midwives (ACNM) is aware of the home birth movement in the United States but encourages institutional births.[139] In 1973, the Executive Board adopted a po-

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[130] LITOFF, MIDWIVES 1860, *supra* note 17, at 142. The public, however, continues to confuse the nurse-midwife with the lay midwife of the past. *Id.*

[131] *Id.* Nurse-midwives employed as nurse-midwives in the United States increased fourteen percent between 1968 and 1971. *Id.*

[132] *Id.* at 142–43. Regardless of these great strides, the development and recognition of nurse-midwives has been slowed by the factors which helped to diminish the importance of midwifery in the early twentieth century. *Id.* at 143.

[133] *Id.* These organizations included the Association for Childbirth at Home (ACAH), Home Oriented Maternity Experience (HOME), Homebirth, Inc., and the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC). While these organizations gladly receive the support of individual medical professionals, these groups also argue that professionals trained to deliver infants in the hospital are not always the best home birth attendants. *Id.*

[134] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 14.

[135] LITOFF, MIDWIVES 1860, *supra* note 17, at 145–46. It is difficult to determine how many lay midwives practice in the United States. *Id.* at 145. In some states lay midwives practice illegally and, therefore, not openly. *Id.*

[136] Brief for Appellant at 29, Leigh v. Board of Registration in Nursing, 399 Mass. 558, 506 N.E.2d 91 (1987) (No. 4173).

[137] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 14–15. Litoff divides midwives into three classes: 1) "old-style" midwives, 2) Certified nurse-midwives, and 3) "a new brand of younger, empirically trained women variously referred to as 'lay,' 'uncertified,' or 'independent' midwives." *Id.*

Nurse-midwives and lay midwives formed the Midwives' Alliance of North America. This organization does not feel that a nursing license must always be a prerequisite for the practice of midwifery. *Id.* at 18.

[138] *See id.* at 17.

[139] LITOFF, MIDWIVES 1860, *supra* note 17, at 144–45.

sition statement encouraging hospital or birth center deliveries.[140] The ACNM's position follows from a goal to promote the professional, regulated status of the nurse-midwife among both physicians and the general public.[141] A study done by ACNM in 1985 identified the two most influential factors in the success of nurse-midwifery practice: suitable collaboration with physicians, and philosophical agreement between the collaborating nurse-midwives and physicians regarding childbirth and practice.[142] Because the vast majority of physicians oppose home births and physician support is necessary for a successful nurse-midwifery practice, an official position by the ACNM encouraging hospital or birth center deliveries is a political necessity.[143]

A split exists, however, among ACNM's members on the issue of home births.[144] Not all nurse-midwives support ACNM's encouragement of institutional deliveries.[145] Some nurse-midwives, in addition to lay midwives, deliver children at home in response to consumer demands for home birth.[146] Thus, while ACNM officially encourages institutional deliveries, a number of its members provide assistance at home births.

Despite ACNM's position encouraging institutional deliveries, states nonetheless may need to regulate midwifery because women continue to choose midwives as birth attendants for home births. While midwives as professionals have progressed from the untrained, ignorant birth attendants of medieval times to the generally skilled, trained and organized midwives of today, regulation of midwifery would provide a framework for the evaluation of midwives as birth attendants, and would assure their expertise. To regulate midwifery rationally, state legislatures must first consider how best to protect the health and safety of women who wish to choose home births, and their infants.

B. *Relative Safety of Childbirth Choices*

The historic trend away from home births finds its basis in the argument that a hospital birth is a safer birth for both mother and

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[140] *Id.*

[141] *See generally* Rooks, *The Context of Nurse-Midwifery in the 1980s*, 28 J. OF NURSE-MIDWIFERY 3 (Sept./Oct. 1983).

[142] Haas and Rooks, *National Survey of Factors Contributing To And Hindering The Successful Practice of Nurse-Midwifery*, 31 J. OF NURSE-MIDWIFERY 212, 214 (1986).

[143] *See* Rooks, *The Context of Nurse-Midwifery in the 1980s*, 28 J. OF NURSE-MIDWIFERY 3 (Sept./Oct. 1983).

[144] LITOFF, MIDWIVES 1860, *supra* note 17, at 144–45.

[145] *Id.*

[146] *Id.*

baby.[147] The safety issues surrounding home birth and midwives, however, are unclear.[148] While the majority of births occur spontaneously, without intervention, the process of birth is a complicated physiological event.[149] A number of physical and psychological factors can alter the progress of a labor tremendously.[150] Thus controversy surrounds the relative safety of childbirth choices.

Proponents of home birth argue that the home is not only psychologically beneficial, but also the safest place to give birth.[151] They urge that the iatrogenic[152] risks of a hospital birth are greater than the risks associated with the limited availability of emergency services at a home birth.[153] Home birth supporters note that a hospital birth usually involves aggressive, if not invasive, intervention during labor and delivery. They argue that this is inappropriate for the low-risk birth.[154]

Increased stress, anxiety, and sometimes fear, home birth supporters note, are associated with a hospital birth. This alone may increase morbidity and mortality for both mother and baby.[155] Moreover, home birth supporters criticize as misleading studies indicating tremendous risks for home births. They state that these statistics include inherently high-risk, unplanned births and planned births which take place without a trained midwife.[156]

Proponents of home birth generally also support midwives as home birth attendants.[157] They point out that reduction of the numbers of midwives attending births has not solved the problem of high infant mortality in the United States.[158] Many European countries which use lay midwives and nurse-midwives as material providers of maternity care have significantly lower infant mortality rates.[159]

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[147] Zander, *supra* note 1, at 231.

[148] *Id.*

[149] *Id.* at 230.

[150] *Id.*

[151] Rantz, *supra* note 2, at 43.

[152] Iatrogenic risks are those risks inadvertently caused by medical intervention. For example, surgery to correct a dangerous condition necessarily causes a risk of infection.

[153] Hoff, *supra* note 2, at 21.

[154] *Id.*

[155] *Id.*

[156] *Id.* at 20. The ACOG has used these studies to show a two to fivefold increase in the risk of perinatal mortality for out-of-hospital births. *Id.*

[157] LITOFF, MIDWIFE DEBATE, *supra* note 7, at 14.

[158] LITOFF, MIDWIVES 1860, *supra* note 17, at 147. The infant mortality rate in the United States declined from 124 deaths per 1,000 live births in 1910 to 18.5 in 1972. *Id.*

[159] *Id.* In 1972 a number of countries reported infant mortality rates below those of the United States, Sweden (10.8 deaths per 1000 births), the Netherlands (11.7 deaths per 1000

Opponents of home birth dispute the contention that home births attended by midwives are as safe or safer than hospital births attended by obstetricians. They argue that it is infinitely more risky, to both mother and baby, to give birth at home.[160] They state that all births should should occur in the hospital because hospital births are safer. In support of their argument, they cite research which indicates that twenty to thirty percent of newborn complications occur in low-risk births.[161]

The ACOG criticizes home birth studies for their methodology.[162] These criticisms include the small numbers of deliveries in

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births), Norway (11.8 deaths per 1000 births), Denmark (12.2 per 1000 births), and England and Wales (17.2 per 1000 births). *Id.* While the maternal mortality rate has declined more successfully, European countries again have lower maternal mortality rates. *Id.*

Litoff notes three major distinctions between the health care programs of these European countries and that of the United States. First, each of these countries have government-sponsored medical insurance programs in contrast to that of the United States which is largely privately funded. Second, European physicians intervene less and practice more conservative obstetrics than American physicians. Last, midwives and nurse-midwives are an integral part of European maternity care. *Id.* at 147–48.

[160] Hoff, *supra* note 2, at 19.

> The primary risk to the mother is massive, life-threatening hemorrhage, either during labor or after the birth due to failure of the uterus to contract or to retain placental fragments. The risks to the fetus include fetal distress and neonatal lack of oxygen due to poor blood supply to the placenta, separation and hemorrhage of the placenta, or umbilical cord accidents. A doctor who was treating the mother in a hospital would rapidly replace blood and fluid and, in some cases, perform an emergency hysterectomy to save her life. The baby would immediately be delivered by caesarean section or forceps. Were these complications to occur at home, the mother or the fetus could die. Death to the fetus from lack of oxygen can occur within five minutes from the time that fetal distress first becomes apparent.
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> In certain high-risk women (for whom home birth is not advisable) the majority of complications in labor and delivery can be predicted. Nevertheless 20 to 30 percent of problems with newborns occur in the low-risk population. Indeed, complications that occur during labor are better predictors of fetal morbidity and mortality than are high-risk factors identified earlier in the pregnancy.

Id. (footnotes omitted).

[161] *Id.*

[162] *Id.* at 20.

> To estimate the risk of home birth in terms of perinatal mortality, one would have to compute perinatal mortality rates for all complications that might occur even under maximal hospital supervision ("unpreventable deaths") and subtract that from the perinatal mortality rates that occur in home births ("preventable deaths" plus "unpreventable deaths"). These data are unavailable. Most studies compare temporal trends of the perinatal mortality rates in specific areas with changes in the home birth rate, or differences in the perinatal mortality rates in countries that report varying proportions of home births. Such comparisons are of little value because of numerous confounding variables.

Id. (footnotes omitted).

the studies, the short duration of the studies, the absence of a control group, and lack of randomization of subjects.[163] The ACOG states that these defects in study methodology necessarily lead to flawed results.[164]

The only recent controlled retrospective study comparing home births and hospital births concluded that the additional medical and obstetrical procedures done in a hospital did not clearly improve the health and safety of mother and baby over the home birth.[165] The study compared 1,046 home births with 1,046 hospital births. Mothers were matched for age, parity, risk factors, and other measures.[166] The study found that although the hospital births were accompanied by significantly greater invasive procedures,[167] no difference existed in perinatal mortality rates between the two groups.[168]

Therefore, legislatures, healthcare professionals, and consumers lack conclusive data about the relative risks of home versus hospital birth, lay midwife versus nurse-midwife, and midwife versus obstetrician. Experts do not agree on a single choice as being the most effective or the best for all situations. Because of the scarcity of well designed, controlled studies comparing childbirth methodologies, additional studies are needed.[169] Until additional, well-designed studies are completed, no conclusive answer on the relative safety of home births versus hospital births is available.

Despite the lack of clearcut data on childbirth methodologies, states have a legitimate interest in protecting the health and safety of women and infants.[170] The state may fulfill its obligation to protect its citizens' health and safety in the area of childbirth by regulating health care professionals, including midwives, and by assuring that they practice within their state defined roles.[171] The

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[163] *Id.*

[164] *Id.*

[165] *Id.* "It therefore seemed appropriate to conclude that for low medical risk women home delivery is an alternative that cannot be dismissed as contraindicated because of an unacceptable high risk to maternal or infant health." *Id.* (quoting L.E. Mehl, *Research on Alternatives in Childbirth, What Can It Tell Us About Hospital Practice?*, 2 TWENTY-FIRST CENTURY OBSTETRICS NOW 171–207 (1977)).

[166] Hoff, *supra* note 2, at 20.

[167] *Id.* Invasive procedures including caesarean sections, forceps, episiotomies. *Id.*

[168] *Id.*

[169] *Id.* at 25.

[170] *See* Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560–61, 506 N.E.2d 91, 93 (1987).

[171] *See Leigh II*, 399 Mass. at 561, 506 N.E.2d at 93.

state also legitimately may choose to encourage hospital births until medical research clearly decides the safety issues of home birth and hospital birth.[172] The state has a legitimate interest in protecting the health and safety of its citizens and therefore may establish reasonable regulations for childbirth and childbirth attendants.[173] Controversy, however, surrounds the relative safety of various childbirth choices. Thus, how a state should best protect the health and safety of its citizens in the area of childbirth is unclear.

II. Regulation of Midwives in the United States

State legislatures have addressed safety concerns regarding home birth and birth attendants in various ways. All fifty states and the District of Columbia regulate nurse-midwifery.[174] In great contrast, only twenty-three states regulate the practice of midwifery by lay midwives.[175] Some states make lay midwifery illegal.[176] Other states do not make the practice of lay midwifery illegal but also do not regulate it.[177] Thus, the status of lay midwives as professionals differs tremendously from state to state.

While all fifty states and the District of Columbia regulate nurse-midwifery, only twenty-one states and the District of Columbia specifically name nurse-midwives in the authorizing statute.[178]

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[172] *See id.*

[173] *See infra* note 312 and accompanying text.

[174] *See supra* note 39.

[175] *See supra* note 40.

[176] Litoff, Midwife Debate, *supra* note 7, at 17. The legal status of lay midwives in the various jurisdictions is far from clear. For example, Florida adopted a Midwifery Practice Act in 1982 which modernized prior existing law. In 1984, however, the Florida legislature amended this statute to provide that no new students could study in the midwifery schools established by the 1982 Act. *Id.*

[177] *See, e.g.*, Massachusetts, Wisconsin and Tennessee, as discussed *infra* notes 184–221 and accompanying text.

[178] *See* Ala. Code § 34-19-2 (1985); Ariz. Rev. Stat. Ann. § 36-752.A.2 (1956); Ark. Stat. Ann. §§ 17-86-501–17-86-507 (1987); Cal. Bus. & Prof. Code §§ 2746–2746.8 (West Supp. 1988); Colo. Rev. Stat. § 12-36-106(1)(f) (1985); Conn. Gen. Stat. §§ 20-86a–20-86e (Supp. 1987); D.C. Code Ann. § 2-3306.2 (Supp. 1987); Fla. Stat. Ann. § 464.012 (West 1981 & Supp. 1987); Ky. Rev. Stat. Ann. § 314.011 (Michie/Bobbs-Merrill 1983 & Supp. 1986); Md. Health Occ. Code Ann. §§ 7-601–7-603 (1986); Mass. Gen. L. ch. 112, §§ 80C–80D (1986); 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.); Mich. Stat. Ann. § 14.15(17210) (Callaghan 1980); Mont. Code Ann. § 37-8-409 et seq. (1987); Neb. Rev. Stat. §§ 71-1738–71-1765 (1986); N.Y. Pub. Health Law § 2560 (McKinney 1985); N.C. Gen Stat. §§ 90-178.1–90-178.7 (1985); Ohio Rev. Code Ann. §§ 4731.30, 4731.32, 4731.33 (Baldwin 1984 & Supp. 1987); Okla. Stat. Ann. tit. 59, §§ 577.1–577.6 (West Supp. 1988); S.D. Codified Laws Ann. § 36-9A (1986); Utah Code Ann. §§ 58-44-1–58-44-11 (1986 & Supp. 1987); W.

Twenty-two states name nurse-midwives only in the regulations.[179] Nine states do not specifically name nurse-midwives in either the authorizing statute or the regulations.[180]

VA. CODE §§ 30-15-1–30-15-8 (1986); WIS. STAT. ANN. § 441.15 (West 1988). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

[179] *See generally* Mullinax, *supra* note 42, at 156–180, 222–253. The following states name nurse-midwives only in their regulations: Delaware, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, New Hampshire, New Jersey, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Vermont, Virginia, and Wyoming. *See id.* at 157.

[180] *See generally id.* at 156–180, 222–253. The following states do not name nurse-midwives in either their statutes or regulations: Alaska, Illinois, Minnesota, Mississippi, Missouri, Nevada, Pennsylvania, Rhode Island, and Washington. *See id.* at 157.

Regulatory schemes also vary as to the authority charged with regulating nurse-midwifery practice. In thirty-three states and the District of Columbia, the Board of Nursing regulates nurse-midwifery practice, regardless of whether or not the statute specifically names nurse-midwives. *See* ALASKA STAT. § 08.68.100 (1987); ARIZ. REV. STAT. ANN. § 36-752.A.2 (1956); ARK. STAT. ANN. § 17-86-503 (1987); CAL. BUS. & PROF. CODE § 2746 (West Supp. 1988); D.C. CODE ANN. § 2-3306.4 (Supp. 1987); FLA. STAT. ANN. § 464.003(c) (West 1981 & Supp. 1987); GA. CODE ANN. § 43-26-4 (1984); IDAHO CODE § 54-1404 (1979 & Supp. 1987); ILL. ANN. STAT. ch. 111, para. 3407 (Smith-Hurd 1978 & Supp. 1987); IOWA CODE ANN. §§ 152.1–152.10 (West 1972 & Supp. 1987); KAN. STAT. ANN. §§ 65-1113–65-1134 (1985); KY. REV. STAT. ANN. § 314.042 (Michie/Bobbs-Merrill 1983 & Supp. 1986); LA. REV. STAT. ANN. § 37:918 (West 1974 & Supp. 1987); ME. REV. STAT. ANN. tit. 32, §§ 2101–2258 (1978 & Supp. 1986); MD. HEALTH OCC. CODE ANN. §§ 7-201, 7-205, 7-602 (1986); MASS. GEN. L. ch. 112, § 80C (1986); 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.); MICH. STAT. ANN. § 14.15(17210) (Callaghan 1980); MINN. STAT. §§ 148.171–148.285 (1980); MISS. CODE ANN. § 73-15-17 (1972 & Supp. 1987); MO. ANN. STAT. § 335.036 (Vernon 1966 & Supp. 1988); MONT. CODE ANN. §§ 37-8-102, 37-8-409 (1987); NEB. REV. STAT. §§ 71-1738–71-1765 (1986); NEV. REV. STAT. ANN. § 632.120 (Michie 1986 & Supp. 1987); N.H. REV. STAT. ANN. § 326-B:4 (1984 & Supp. 1987); N.D. CENT. CODE § 43-12.1-08 (1978 & Supp. 1987); OKLA. STAT. ANN. tit. 59, § 577 (West Supp. 1988); OR. REV. STAT. § 678 (1987); S.C. CODE ANN. § 43-33 (Law. Co-op. 1986 & Supp. 1987); TENN. CODE ANN. § 63-7-207 (1986); TEX. REV. CIV. STAT. ANN. art. 4513–4525 (Vernon 1976 & Supp.1988); VT. STAT. ANN. tit. 26, §§ 1571–1584 (Supp. 1987); WASH. REV. CODE ANN. § 18.88.080 (1978 & Supp. 1987); W. VA. CODE § 30-15-1 (1986); WIS. STAT. ANN. § 441.15 (West 1988); WYO. STAT. ANN. § 33-21-122 (Michie 1987). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

The Board of Nursing and the Board of Medicine jointly regulate nurse-midwifery practice in four states. *See* ALA. CODE § 34-19-10 (1985); NEB. REV. STAT. §§ 71-1743, 71-1755 (1986); S.D. CODIFIED LAWS ANN. § 36-9A (1986); VA. CODE ANN. § 54-274 (1982 & Supp. 1987). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

The Board of Medicine regulates nurse-midwifery practice in four states. *See* IND. CODE ANN. § 25-22.5-2-7 (Burns 1982 & Supp. 1987); N.J. STAT. ANN. § 45:10-2 (West 1978 & Supp. 1987); OHIO REV. CODE ANN. §§ 4731.30, 4731.32, 4731.33 (Baldwin 1984 & Supp. 1987); PA. STAT. ANN. tit. 63, § 171 (Purdon 1968). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

The Department of Public Health regulates nurse-midwifery practice in six states. *See* CONN. GEN. STAT. § 20-86c (Supp. 1987); DEL. CODE ANN. tit. 16, § 122(3)(h) (1974 & Supp. 1986); HAW. REV. STAT. § 321-13 (1985); N.M. STAT. ANN. § 61-6-16.c (1978); N.Y. PUB. HEALTH LAW § 2560 (McKinney 1985); R.I. GEN. LAWS §§ 23-13-9, 23-13-10 (1956). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

Jurisdictions also differ in the authority given to nurse-midwives. Sixteen states and the District of Columbia grant prescriptive authority to nurse-midwives.[181] Three states do not allow nurse-midwives to attend home births.[182] Thus, the fifty states and the District of Columbia regulate nurse-midwives but these regulations vary from jurisdiction to jurisdiction.

As with nurse-midwifery, the regulatory schemes affecting lay midwifery differ from jurisdiction to jurisdiction. Twenty-three states do not prohibit the practice of lay midwifery.[183] Two jurisdictions, while prohibiting nurse-midwives from attending home births, do not regulate or prohibit lay midwifery.[184] State legislatures may need to address the regulation of lay midwifery to protect the safety of women and infants effectively.

A. *Present Regulation of Midwives in Wisconsin, Tennessee, Massachusetts and Texas*

Twenty-three state legislatures recognize lay midwifery.[185] The majority of states, however, do not regulate lay midwifery.[186] As examples, this section will present the regulatory schemes of Wis-

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The Committee of Certified Nurse-Midwifery regulates nurse-midwifery practice in two states. *See* N.C. GEN STAT. §§ 90-178.4–90-178.7 (1985); UTAH CODE ANN. §§ 58-44-4, 58-44-8 (1986 & Supp. 1987). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

In one state, Colorado, nurse-midwifery is regulated by a number of agencies. *See* COLO. REV. STAT. § 12-36-106 (1985). *See generally* Mullinax, *supra* note 42, at 156–180, 222–253.

[181] ALASKA ADMIN. CODE tit. 12, § 44.010 et seq. (April 1988); ARIZ. REV. STAT. ANN. § 32-1921 (1956); D.C. CODE ANN. § 2-3306.6(b)(7) (Supp. 1987); Idaho (Bd. of Nursing, "Nurse Practitioners, Minimum Standards, Rules and Regulations," tit. 3, ch. 4, §§ 3-4007–3-4009); ME. REV. STAT. ANN. tit. 32, § 2805-21 (1978); MICH. STAT. ANN. § 14.15(17076) (Callaghan 1980 & Supp. 1987); Mississippi (Standards of Practice for Nurse-Midwifery in the State of Miss., § II(B)); NEV. REV. STAT. ANN. § 639.1375 (Michie 1986); N.H. REV. STAT. ANN. § 326-B:10(II) (1984); New Mexico (HED-80-6, 301–303); N.C. GEN. STAT. § 90-18.2(b) (1985); OR. REV. STAT. §§ 678.375, 678.385, 678.390 (1988); S.D. CODIFIED LAWS ANN. § 36-9A-13 (1986); TENN. CODE ANN. §§ 63-7-123, 63-7-207 (1986); Utah; VT. STAT. ANN. tit. 26, § 2022(7) (Supp. 1987); WASH. REV. CODE ANN. § 18.64.0118 (Supp.1987). *See generally* Mullinax, *supra* note 42, at 158.

[182] Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 481 (Tenn. Ct. App. 1980); ALA. CODE § 34-19.8 (1985); WIS. STAT. ANN. § 451.15(1)(b) (West 1988). While Tennessee statutes and regulations do not prohibit nurse-midwives from attending home births, Tennessee case law indicates that nurse-midwives may not attend home births. *See supra* notes 44–45.

[183] *See supra* note 40.

[184] *Leggett*, 612 S.W.2d at 481 (Tenn. Ct. App. 1980); WIS. STAT. ANN. § 451.15 (West 1988).

[185] *See supra* note 40.

[186] *See* LITOFF, MIDWIFE DEBATE, *supra* note 7, at 17. *See generally* Mullinax, *supra* note 42, at 160.

consin and Tennessee, two jurisdictions that prohibit nurse-midwives from attending home births but do not regulate lay midwives, Massachusetts, a jurisdiction that now allows nurse-midwives to attend home births but does not regulate lay midwives, and Texas, a jurisdiction that regulates both nurse-midwifery and lay midwifery.

Wisconsin regulates nurse-midwives but does not regulate lay midwives.[187] Nurse-midwives practice under a section of the Board of Nursing statute.[188] The Wisconsin Board of Nursing statute prohibits nurse-midwives from attending births outside a licensed facility.[189] Therefore, nurse-midwives may not attend home births legally.[190]

In contrast to its treatment of nurse-midwives, Wisconsin does not regulate lay midwives.[191] Lay midwives are free to legally attend home births because they are unregulated.[192] Thus, both nurse-midwives and lay midwives practice legally in Wisconsin, but only unregulated lay midwives may attend home births.

Similarly to Wisconsin, Tennessee regulates the practice of nurse-midwifery, but does not regulate the practice of lay midwifery.[193] Nurse-midwives practice under the general parameters of the Nursing Statute.[194] The Tennessee Nursing Statute allows generally for expanded roles of nurses.[195] Only the regulations of the Board of Nursing specifically name nurse-midwives.[196] While the regulations of the Board of Nursing do not explicitly preclude nurse-midwives from attending home births,[197] Tennessee case law indicates that nurse-midwives may not attend home births.[198]

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[187] WIS. STAT. ANN. § 441.15 (West 1988). *See generally* Mullinax, *supra* note 42, at 251.

[188] WIS. STAT. ANN. § 441.15 (West 1988). In 1980, the Wisconsin legislature enacted a separate section of the Board of Nursing statute to regulate nurse-midwifery. The Wisconsin Board of Nursing regulates nurse-midwives. *Id.*

[189] *Id.*

[190] *Id.*

[191] Mullinax, *supra* note 42, at 251. The Wisconsin Medical Practice Act only regulates midwives certified before May 7, 1953. WIS. STAT. ANN. § 448.10(5) (West 1988).

[192] Lay midwives are not illegal but are unregulated; therefore, their practice can consist of attending home births.

[193] Nurse-midwives practice under regulations promulgated pursuant to TENN. CODE ANN. §§ 63-7-101–63-7-209 (1986). The practice of lay midwifery is excluded from the practice of medicine by TENN. CODE ANN. § 63-6-204(a) (1986). *See* Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 480. *See generally* Mullinax, *supra* note 42, at 243–244.

[194] TENN. CODE ANN. §§ 63-7-101–63-7-209 (1986).

[195] TENN. CODE ANN. § 63-7-123 (1986) (providing for expanded role as nurse practitioner); Mullinax, *supra* note 42 at 243.

[196] Mullinax, *supra* note 42, at 157, 243. Nurse-midwives may obtain prescriptive authority separately if they meet the Board of Nursing's qualifications for prescriptive authority. *Id.* at 159, 243.

[197] TENN. COMP. R. & REGS. tit. 63, ch. 1000-4 (1986).

[198] Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 481.

Because the Medical Practice Act specifically excludes midwifery, the practice of lay midwifery is not illegal in Tennessee.[199] Lay midwifery, however, is also not regulated.[200] Lay midwives, consequently, freely attend home births.[201] Thus, in Tennessee, as in Wisconsin, regulated nurse-midwives are prohibited from attending home births while lay midwives, completely unregulated, assist home births.

As in Wisconsin and Tennessee, in Massachusetts the practice of nurse-midwifery and lay midwifery is legal.[202] Unlike Wisconsin and Tennessee, however, both nurse-midwives and lay midwives may assist home births.[203] Nurse-midwives practice midwifery in Massachusetts under portions of the 1977 Nurse Practice Act.[204] The Board of Nursing regulates nurse-midwives in Massachusetts.[205] The Massachusetts legislature amended the Nurse Practice Act in June 1987 to allow nurse-midwives to assist home births.[206] While Massachusetts regulates nurse-midwives, it does not regulate lay midwives[207] and does not prohibit them from attending home births.[208] Thus, both Massachusetts' nurse-midwives and lay midwives legally may attend home births.

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[199] *Id.*; TENN. CODE ANN. § 63-6-204 (1986); Mullinax, *supra* note 42, at 243.

[200] Mullinax, *supra* note 42, at 243.

[201] Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560, 506 N.E.2d 91, 93 (1987). MASS. GEN. L. ch. 112, §§ 80C, 80D (1986).

[202] 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.). Lay midwives are not illegal in Massachusetts; therefore their practice can consist of attending home births.

[203] MASS. GEN. L. ch. 112, §§ 80C, 80D (1986).

[204] MASS. GEN. L. ch. 112, § 80C (1986); Mullinax, *supra* note 42, at 157. Neither the Massachusetts Nurse Practice Act nor the Board of Nursing's regulations give nurse-midwives prescriptive authority. Mullinax, *supra* note 42, at 158. Prior to June 1987, Massachusetts followed a statutory approach similar to that of Wisconsin and Tennessee. *See supra* notes 192–93 and accompanying text. The Massachusetts Nurse Practice Act implicitly prohibited nurse-midwives from attending home births. *See* MASS. GEN. L. ch. 112, § 80C (1986).

[205] 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.).

[206] Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560, 506 N.E.2d 91, 93 (1987). The 1901 Medical Practice Act of Massachusetts specified obstetrics as an area of medical practice reserved exclusively to physicians. LITOFF, MIDWIVES 1860, *supra* note 17, at 56. This is in contrast to the majority of states enacting similar legislation. The Massachusetts Medical Practice Act does not distinguish midwifery from medical practice. *Id.*

Failing to distinguish midwifery from medical practice left the legality of lay midwifery in doubt until the Leigh v. Board of Registration in Nursing decision of 1985 (*Leigh I*), which held that midwifery was not the practice of medicine. 395 Mass. 670, 680, 481 N.E.2d 1347, 1353 (1985).

[207] Because lay midwives in Massachusetts are unregulated, they may practice in any way they desire.

[208] TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

Unlike Wisconsin, Tennessee, and Massachusetts, Texas regulates both nurse-midwives and lay midwives.[209] Both nurse-midwives and lay midwives legally attend home births in Texas.[210] Nurse-midwives practice under the Nurse Practice Act.[211] Lay midwives practice under a lay midwifery practice act.[212]

Nurse-midwives practice as Advanced Nurse Practitioners in Texas. The Texas legislature amended the Nurse Practice Act in 1981 to clarify the Board of Nursing's jurisdiction to regulate Advanced Nurse Practitioners.[213] The regulations pursuant to this amendment specify the qualifications for and the requirements to practice as a nurse-midwife in this state.[214] Texas does not prohibit nurse-midwives from attending home births.[215]

While the Board of Nursing regulates nurse-midwives, the Texas Department of Health regulates lay midwives pursuant to a 1983 lay midwifery practice act.[216] The Texas lay midwifery act provides standards for education and training of lay midwives,[217]

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[209] *Id.*

[210] TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp. 1988).

[211] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

[212] TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp.1988); Mullinax, *supra* note 42, at 245.

[213] Mullinax, *supra* note 42, at 245. While nurse-midwives do not have independent prescriptive privileges, the Texas Medical Practice Act provides for physicians delegating this privilege to nurse-midwives. TEX. REV. CIV. STAT. ANN. art. 4495B § 1.02 (Vernon Supp. 1988).

[214] *See* TEX. REV. CIV. STAT. ANN. art. 4513–4528c. (Vernon 1976 & Supp. 1988).

[215] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

[216] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

> TRAINING COURSE
>
> Sec. 10. (a) An approved lay midwifery training course may be offered by a local health department, an accredited postsecondary educational institution, or an adult education program . . . .
>
> EXAMINATION
>
> Sec. 11. (a) A person who has completed an approved lay midwifery training course or who has comparable training approved by the lay midwifery board is entitled to take the final examination of the training course.

Id.

[217] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

> IDENTIFICATION REQUIREMENT
>
> Sec. 13. (a) In December of each year, a person who practices lay midwifery shall identify himself as a lay midwife by appearing in person before the county clerk of the county in which the person resides or before the county clerk of each county in which the person practices lay midwifery and delivering to the county clerk a verified identification form . . . .
>
> ROSTER
>
> Sec. 15. (a) The department shall maintain a roster of all persons identified to practice lay midwifery.

Id.

and sets forth a procedure for registration of lay midwives.[218] The statute specifies consumer disclosure requirements for lay midwives.[219] It lists several procedures that the lay midwife may and may not perform.[220] This Act lastly provides for a study of the practice of lay midwifery in Texas.[221] The Texas Department of

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[218] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

DUTIES OF LAY MIDWIVES; DISCLOSURE REQUIREMENT

Sec. 16. (a) Each lay midwife shall disclose in oral and written form to a prospective client the limitations of the skills and practices of a lay midwife.

(b) The department with the advice of the lay midwifery board shall prescribe the form of the written disclosure required by this section, which shall include the information that a lay midwife:

(1) may assist only in normal childbirth;

(2) has or does not have an arrangement with a local physician for referring patients who have complications that occur before or during childbirth;

(3) may not administer a prescription drug without a physician's supervision, perform a Caesarean section, or perform an episiotomy; and

(4) has or has not passed the lay midwife training course final examination approved by the board.

Id.

[219] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988).

DUTIES OF LAY MIDWIVES; DISCLOSURE REQUIREMENT

Sec. 16. . . .

(e) A lay midwife shall encourage a client to seek prenatal care.

(f) A lay midwife shall encourage a client to seek medical care if the lay midwife recognizes a sign or symptom of a complication to the client's childbirth.

(g) Each lay midwife shall disclose to a prospective or actual client the procedure for reporting complaints with the department.

PROHIBITED ACTS

Sec. 17. A lay midwife may not:

(1) administer a prescription drug to a client except under the supervision of a licensed physician in accordance with the laws of this state;

(2) use forceps or surgical instruments for any procedure other than cutting the umbilical cord or providing emergency first aid during delivery;

(3) remove placenta by invasive techniques;

(4) advance or retard labor or delivery by using medicines or mechanical devices;

(5) use in connection with his name a title, abbreviation or any designation tending to imply that he is a "registered" or "certified" lay midwife as opposed to one who has identified himself in compliance with this Act; or

(6) assist at childbirth other than a normal childbirth except in an emergency situation that poses an immediate threat to the life of the mother or newborn.

Id.

[220] TEX. REV. CIV. STAT. ANN. art. 4512i (Vernon Supp. 1988). "Sec. 23. REPORT. The department shall study the practice of lay midwifery in the state, including the quality of the services provided by lay midwives and the efficacy of the training program, disclosure requirements, and prohibitions established in this Act." *Id.*

[221] *See, e.g.*, Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560–61, 506 N.E.2d 91, 93 (1987) (equal protection challenge was in addition to other grounds).

Public Health, therefore, regulates lay midwifery pursuant to a very specific lay midwifery practice act.

Thus, while Texas regulates lay midwives, Wisconsin, Tennessee, and Massachusetts have attempted to protect the health and safety of their citizens only through the regulation of nurse-midwifery. Wisconsin, Tennessee, and Massachusetts have failed to address the regulation of lay midwifery. In addition, Wisconsin and Tennessee prohibit nurse-midwives from attending home births. In contrast, the Texas legislature has enacted statutes to regulate both nurse-midwives and lay midwives. To protect the health and safety of their citizens adequately, states may need to regulate the practice of lay midwifery as well as nurse-midwifery. Any regulations a state imposes must pass constitutional scrutiny under the equal protection clause of the fourteenth amendment.

B. *Equal Protection — Standards of Review*

Midwives prosecuted under statutes that differentiate between lay midwives and nurse-midwives attack the statutes on the grounds that such a classification violates the equal protection clause of the fourteenth amendment. [222] The equal protection clause of the fourteenth amendment prohibits states from treating similarly situated persons or classes differently.[223] In order to strike down midwifery statutes as violative of equal protection, a court must find that statutory classifications distinguishing between nurse-midwives and lay midwives do not reasonably further a legitimate state interest.[224]

The United States Supreme Court applies a "mere rationality" test[225] in evaluating classifications that do not involve a suspect

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[222] L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1437–38 (1988).

[223] See discussion of *Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93, *infra* notes 285–89 and accompanying text where court upheld classifications between nurse-midwives and lay midwives because the court found that these classifications rationally furthering a legitimate state purpose.

[224] In Royster Guano Co. v. Virginia, the United States Supreme Court set forth the mere rationality test: "[T]he classification must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation, so that all persons similarly circumstanced shall be treated alike." 253 U.S. 412, 415 (1920).

[225] The Court has accorded suspect classifications a higher level of scrutiny. It subjects classifications based on race or national origin to "strict scrutiny." These classifications must utilize the least restrictive alternative to further a compelling state interest. Korematsu v. United States, 323 U.S. 214, 216 (1944) *reh'g denied*, 324 U.S. 885 (1945); United States v. Carolene Prods. Co., 304 U.S. 144, 152–53 n.4 (1938). The court gives gender based classifications and classifications discriminating on the basis of illegitimacy a slightly lower level of scrutiny. The classification must accomplish an important governmental objective with a

class[226] or infringe on a fundamental right,[227] and has been reluctant to apply a higher level of scrutiny to social and economic regulation.[228] The Court does not strike down statutes merely because the classifications are imperfect. The practical problems of government may justify some inequality if any reasonable basis supports it.[229] If the legislature has a legitimate interest in imposing the challenged economic or social regulation, the statute must merely be rationally related to the law's objective. The law will violate equal protection only if the challenged classification is purely arbitrary.[230] In general, the United States Supreme Court's stance has been one of legislative deference.[231]

The equal protection clause guarantees that people who are similarly situated will not be treated dissimilarly without justification.[232] The Court determines whether persons are similarly or dissimilarly situated in relation to the purpose of the challenged

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means substantially related to that objective. Rostker v. Goldberg, 453 U.S. 57, 69 (1981); Frontiero v. Richardson, 411 U.S. 677, 688–90 (1973); Reed v. Reed, 404 U.S. 71, 75–76 (1971).

[226] The United States Supreme Court has applied the "strict scrutiny" test if a classification significantly burdens the exercise of a fundamental right. Zablocki v. Redhail, 434 U.S. 374, 383 (1978) (marriage and family life); Shapiro v. Thompson, 394 U.S. 618, 630 (1969) (interstate travel); Harper v. Virginia Bd. of Elections, 383 U.S. 618 (1966) (voting).

[227] *See* Dandridge v. Williams, 397 U.S. 471 (1970); J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 524 (1986).

[228] Dandridge v. Williams, 397 U.S. 471, 485 (1970).

> In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classification made by its laws are imperfect. If the classification has some "reasonable basis," it does not offend the Constitution simply because the classification "is not made with mathematical nicety or because in practice it results in some inequality." "The problems of government are practical ones and may justify, if they do not require, rough accommodations — illogical, it may be, and unscientific." "A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it."

Id. (citations omitted). The United States Supreme Court has exercised extreme judicial restraint, aside from cases involving suspect classifications and fundamental rights, in evaluating most statutory challenges based on equal protection. TRIBE, *supra* note 223, at 1439–43.

[229] Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 70 (1911).

[230] McDonald v. Board of Election, 394 U.S. 802, 809 (1969). The Court will invalidate classifications "only if no grounds can be conceived to justify them." *Id.*

[231] TRIBE, *supra* note 223, at 1437–38.

[232] *See* Michael M. v. Sonoma County Superior Court, 450 U.S. 464, 469–71 (1981). The court found that the statutory purpose in this case was to discourage illegitimate teenage pregnancies by making men criminally liable for intercourse with women under eighteen. According to the Court, the legislature possibly could have reasoned that men are differently situated from women because men are not deterred by becoming pregnant. *Id.*

statute.[233] While the legislature's purpose must be legitimate, courts give great deference to the legislature's ability to evaluate its objectives. The Court looks to "conceivable" objectives which might have motivated the legislature.[234] If the objective is not grossly unfair or totally irrational, the Court usually accepts it. A merely ill-advised legislative objective is not illegitimate.[235]

The Court has determined legislative purpose by looking to a statutory statement of purpose or the legislative history of the challenged statute. If the legislative history of the statute clearly states a legislative purpose, the Court uses this "actual" legislative purpose whether or not this purpose actually motivated the statutory enactment.[236] If the Court cannot derive an "actual" legislative purpose, it has on occasion validated a statute by using a hypothetical legislative purpose.[237] In other cases, the Court has declined to hypothesize.[238] Thus, the Court's requirements for a legitimate purpose vary from case to case.[239]

Once the Court determines a legitimate state purpose, it then examines whether the means the legislature has chosen, and the classifications used, rationally relate to this purpose.[240] The Court, in the past, struck down statutes or regulations which employ irra-

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[233] *See supra* note 231.

[234] *See* Daniel v. Family Sec. Life Ins. Co., 336 U.S. 220, 224 (1949).

[235] *See* United States R.R. Retirement Bd. v. Fritz, 449 U.S. 166, 176–77 (1980). Authorities dispute the validity of this approach. The argument for requiring "actual" purpose is to apply "indirect pressure on the legislature to state its own reasons for selecting the particular means and classifications" resulting in fuller debate for each legislative action. Gunther, *The Supreme Court 1971 Term*, 86 HARV. L. REV. 1, 47 (1972).

The argument against requiring "actual" purpose is that it "leaves the judiciary free to strike legislation it finds politically objectionable by attributing to the legislature either an illegitimate purpose or a purpose that, though legitimate, is too far removed from the means selected to withstand even minimum scrutiny." *The Supreme Court 1980 Term*, 95 HARV. L. REV. 93, 160 (1981).

[236] *See* McDonald v. Board of Election, 394 U.S. 802, 809 (1969) (any conceivable basis).

[237] *E.g.*, McGinnis v. Royster, 410 U.S. 263, 277 (1973).

[238] Occasionally the Court will strike down a statute because the purpose is illegitimate. *See* Metropolitan Life Ins. Co. v. Ward, 470 U.S. 869, 878, *reh'g denied*, 471 U.S. 1120 (1985) (promoting the business of domestic insurers by penalizing foreign insurers is not a legitimate state purpose); United States Dept. of Agric. v. Moreno, 413 U.S. 528, 534–35 (1973) (possible desire to exclude "hippi communes" from the federal food stamp program is not a legitimate state purpose).

[239] *See* TRIBE, *supra* note 223, at 1440.

[240] In Morey v. Doud, the Court determined the legitimate purpose was "to protect the public when dealing with currency exchanges." 354 U.S. 457, 464 (1957). Discriminating in favor of a specific company, however, was not rationally related to that purpose. *Id.* at 466. The Court subsequently overruled this analysis in City of New Orleans v. Duke, 427 U.S. 297, 306 (1976).

tional, arbitrary methods, or classifications, to further a permissible objective.[241] In the majority of cases, however, the Court has not invalidated statutes or regulations provided the classifications might rationally relate to a legitimate state purpose.[242]

Because the chosen classification might rationally relate to a legitimate state purpose, the Court is reluctant to invalidate a statute because its means are under-inclusive or its means do not burden or benefit all persons who are similarly situated.[243] The Court reasons that "[i]t is no requirement of equal protection that all evils of the same genus be eradicated or none at all."[244] Thus, the Court will not strike down a statute merely because the legislature failed to address all factors related to its legitimate purpose.[245]

The most common statutory classifications are under-inclusive with regards to some classes, but over-inclusive[246] for other classes.[247] In other words they do not burden all persons similarly situated, but they burden some persons who are not similarly situated. Invalidation of these statutes depends on the Court's characterization of the statute and the degree of threatened or actual harm.[248]

Because of the Court's deference to the legislature, invalidation of social or economic statutes on equal protection grounds occurs

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[241] *See* TRIBE, *supra* note 223, at 1442–43.

[242] *See id.* at 1446–49.

[243] Railway Express Agency v. New York, 336 U.S. 106, 110 (1949). Denying under-inclusive statutes meaningful review, however, may encourage legislatures to discriminate against political minorities which will result in dissimilar treatment for persons similarly situated. *See* TRIBE, *supra* note 223, at 1447–48.

[244] If the Court strikes down under-inclusive statutes, states may avoid attacking a problem at all if their resources are inadequate. Political factions may never agree to attack all the various aspects of a particular problem. *Developments in the Law — Equal Protection*, 82 HARV. L. REV. 1065, 1085 (1969). *See* Tussman & tenBroek, *The Equal Protection of the Laws*, 37 CALIF. L. REV. 341, 348 (1949).

[245] The Court is more willing to strike down statutes which are over-inclusive or which extend burdens or benefits to more than those persons who are similarly situated. Over-inclusive laws which burden some persons who should not have been burdened appeal to the Court's sense of fairness. *Developments*, *supra* note 245, at 1086.

[246] Tussman, *supra* note 245, at 352.

[247] NOWAK, *supra* note 228, at 528.

[248] Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560–61, 506 N.E.2d 91, 93 (1987). *See also*, Minnesota v. Clover Leaf Creamery Co., 449 U.S. 456, 461–62, 470, *reh'g denied*, 450 U.S. 1027 (1981) (Ban on plastic nonreturnable milk containers bears a rational relation to the state's theoretical objectives.); Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307, 314 (1976) (Mandatory retirement age rationally furthered state's purpose of "assuring physical preparedness of its uniformed police."). If a statute's rationality is debatable, the Court upholds a somewhat attenuated connection between purpose and method. TRIBE, *supra* note 223, at 1445–46.

only in a small minority of cases. Midwifery statutes are social statutes regulating professions permitted to exist by the state. If in enacting a statute regulating midwifery, a legislature has a legitimate state purpose, and if the classification rationally furthers this purpose, a court would uphold the statute.[249] Thus, midwifery statutes are unconstitutional only if the means selected by the statute are not reasonably related to a legitimate state interest.

C. *State Court Treatment of Midwifery*

Tennessee and Massachusetts courts have addressed challenges to midwifery regulations under the equal protection clause of the fourteenth amendment.[250] These cases raise several issues regarding the legal ability of a nurse to practice midwifery. The midwifery regulatory scheme may preclude only nurses, and no other single group, from practicing midwifery as lay midwives.[251] A regulatory scheme also may preclude a nurse from functioning as a lay midwife only under some circumstances.[252] If the regulatory scheme precludes only nurses from practicing lay midwifery and does not reasonably further a legitimate state interest, it may violate the equal protection guarantee of the fourteenth amendment.[253]

Tennessee courts have addressed the issue of whether a nurse can choose to practice as a lay midwife as opposed to a nurse-midwife. In *Leggett v. Tennessee Board of Nursing*, the Tennessee Court of Appeals held that the Board of Nursing could not discipline a nurse who practiced as a lay midwife independent of her role as a nurse.[254] The court reasoned that the Board of Nursing

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[249] *Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93; Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 480 (1980) (dictum).

While Texas courts have not addressed midwifery regulations in an equal protection context, they have addressed the relationship between the practice of midwifery and the practice of medicine. Banti v. State, 163 Tex. Crim. 89, 92–93, 289 S.W.2d 244, 247 (1956). Prior to the enactment of midwifery statutes, the Texas Court of Criminal Appeals held that midwifery was not the unlicensed practice of medicine. *Id.* The court reasoned that childbirth was a normal physiological event, not a disease. *Id.* at 92, 289 S.W.2d at 247. It noted that the legislature failed to include maternity care within its definition of the practice of medicine. *Id.* at 92–93, 289 S.W.2d at 247. Therefore, the *Banti* court, in its discretion, concluded that midwifery was not the practice of medicine.

Wisconsin courts have not addressed the regulatory issues of midwifery.

[250] *See Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93.

[251] *See Leggett*, 612 S.W.2d at 481 (A nurse functioning as a lay midwife may not use his or her nursing license to perform functions a lay person could not perform.).

[252] *See id.* at 480 (dictum).

[253] *Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93; *Leggett*, 612 S.W.2d at 481.

[254] 612 S.W.2d 476, 481 (1980).

lacked jurisdiction over lay midwives and that nurse-midwifery regulations do not apply to lay midwives or nurses practicing as lay midwives.[255]

In *Leggett*, Elizabeth Leggett, a licensed registered nurse, delivered approximately fifty babies as a lay midwife.[256] She was neither certified as a nurse midwife nor qualified to be certified.[257] She did not hold herself out as a nurse to her clients.[258] The Board of Nursing revoked Leggett's license because she attended births without being certified as a nurse-midwife and Leggett brought an appeal.[259]

The court held that the Board of Nursing does not have jurisdiction over a nurse when she provides services as a lay midwife independently of her status as a nurse.[260] The court reasoned that the authorizing legislation did not give jurisdiction over lay midwifery to the Board of Nursing.[261] The court additionally refused to apply nursing regulations to Leggett in her practice as a lay midwife.[262] Lastly, the court noted that the Board of Nursing failed to show that Leggett's practice as a lay midwife adversely affected her skill or ability to practice as a registered nurse. The court analogized revocation of a nurse's license, under these facts, to a revocation for "serving occasionally as a secretary or receptionist."[263]

The court indicated, in dicta, that imposing nursing regulations on a nurse practicing midwifery independent of his or her status as a nurse would impose a burden on nurses which was not imposed upon other similarly situated lay midwives.[264] The court doubted that this discriminatory classification could pass constitutional scrutiny.[265] The court also indicated that such an application of nursing regulations would not be reasonably related to promoting the legitimate state purpose of ensuring public health because it would allow

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[255] *Id.* at 479–80.

[256] *Id.* at 478.

[257] *Id.* at 477.

[258] *Id.* at 480. While Leggett did not tell her clients she was a nurse, she did dispense a medication to them that was not available to laypersons without a perscription. *Id.* at 473, 481.

[259] *Id.* at 477.

[260] *Id.* at 481.

[261] *Id.* at 479–80. The court noted that 1) the legislature specifically excludes midwifery from the practice of medicine and 2) the Nurse Practice Act does not deal with midwifery or include it within the definition of professional nursing. *Id.*

[262] *Id.* at 480.

[263] *Id.*

[264] *Id.*

[265] *Id.*

anyone, except regulated nurses, to attend home births.[266] Thus, the court in *Leggett* indicated that preventing a nurse from practicing midwifery outside her role as a nurse does not rationally further a legitimate state purpose and is not constitutional.[267]

Unlike the Tennessee court which addressed the issue in dicta, a Massachusetts court directly addressed the issue of whether revoking a nurse's license for the practice of lay midwifery violates the equal protection clause of the fourteenth amendment.[268] The Supreme Judicial Court of Massachusetts has held that revoking a nurse's license for the practice of lay midwifery does not violate the equal protection clause.[269] Janet Leigh, a nurse practicing lay midwifery in Massachusetts, unsuccessfully challenged the revocation of her nursing license on equal protection grounds.[270] In *Leigh I*, the Supreme Judicial Court of Massachusetts determined that the practice of lay midwifery was not prohibited by statute in Massachusetts.[271] The court reasoned that ordinary assistance in childbirth, midwifery, is not the practice of medicine.[272]

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[266] *Id.* at 481.

> No one questions that in an emergency a mother and infant are better off in a hospital with a certified nurse-midwife or a physician. But given that some couples will continue to decide on home deliveries, the Board's decision overlooks the fact that certified nurse-midwives cannot participate in home deliveries.
>
> The Board's decision if allowed to stand would mean that anyone except licensed nurses could act as midwives. This is contrary to the goal of promoting public health.

Id. (quoting Chancellor's opinion below).

[267] The only other reported Tennessee case dealing with midwifery is Nurse Midwifery Assoc. v. Hibbett, 549 F. Supp. 1185 (M.D. Tenn. 1982). In this case a nurse-midwife challenged her denial of malpractice insurance on antitrust grounds. This note does not address this issue.

[268] Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560–61, 506 N.E.2d 91, 93 (1987). Previously, in its 1907 decision, Commonwealth v. Porn, the Supreme Judicial Court of Massachusetts upheld the constitutionality of the 1901 Medical Practice Act reserving obstetrics to physicians as an area of medical practice. 196 Mass. 326, 82 N.E. 31 (1907). In *Porn*, a midwife was tried and convicted in the Superior Court for illegally practicing medicine. *Id.* The court noted that while Porn did not hold herself out as a medical practitioner, the Medical Practice Act defined the practice of medicine to include obstetrics, the practice of midwifery. *Id.* at 327–28, 82 N.E.2d at 31. In common usage, midwifery meant obstetrics. *Id.* The court indicated that the legislature was able to separate the practice of midwifery from the practice of medicine but had chosen not to do so. *Id.* at 328, 82 N.E. at 32. Thus, in Massachusetts during this time, a midwife could not legally practice her profession. *See* LITOFF, MIDWIVES 1860, *supra* note 17, at 56.

[269] *Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93.

[270] *See infra* notes 271–89 and accompanying text.

[271] 395 Mass. 670, 679, 481 N.E.2d 1347, 1353 (1985).

[272] *Id.* at 677–80, 481 N.E.2d at 1353. The court factually distinguished the midwife in

The court reviewed the Board of Registration in Nursing's action suspending Janet Leigh's license to practice as a registered nurse.[273] The Board found that she was attending women at home births in violation of the Nurse Practice Act.[274] The Board determined that Leigh informed clients of her status as a registered nurse with obstetrical training.[275]

The Board stated that Leigh was in violation of the Nurse Practice Act on two counts. First, she was not certified or authorized to practice as a nurse-midwife. Second, even if she were a nurse-midwife, both a statute and regulations prohibit nurse-midwives from attending women at home births.[276] The Board concluded that Leigh was a registered nurse engaged in the unauthorized practice of midwifery and suspended her nursing license for one year.[277] Leigh sought review of the Board's decision.[278]

The court held that the Board had the power to discipline Leigh only on the basis that she violated the Nurse Practice Act and the regulations promulgated thereunder. The court noted, however, that the Board had no power to discipline Leigh for the mere practice of midwifery.[279] The court stated that "[t]he Legislature has not regulated midwifery by persons other than nurses."[280] The court remanded to the Board for further determinations on whether Leigh had violated the Nurse Practice Act.[281]

On remand, the Board again suspended Leigh's license to practice as a registered nurse on the basis that she violated the Nurse Practice Act and its associated regulations.[282] Leigh again appealed

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Porn as having been convicted for the unauthorized practice of medicine because she had used obstetrical instruments and prescriptions in caring for her patients. The court interpreted midwifery to mean "ordinary assistance in the normal cases of childbirth" and confined the holding of *Porn* to its facts. *Id.*

[273] *Id.* at 672, 481 N.E.2d at 1349. Leigh was seeking review of the Board's decision for a second time. *Id.*

[274] *Id.*at 673, 481 N.E.2d at 1349.

[275] *Id.* Additionally, Leigh used obstetrical instruments during some births. *Id.*

[276] *Id.* Leigh argued that she was practicing lay midwifery which is outside the practice of nursing. *Id.* at 678, 481 N.E.2d at 1351.

[277] *Id.* at 674–75, 481 N.E.2d at 1350. The Board argued that midwifery practiced outside of nursing or obstetrics (i.e. lay midwifery) was illegal in Massachusetts. *Id.* at 678 n. 7, 481 N.E.2d at 1352, n. 7.

[278] *Id.* at 672, 481 N.E.2d at 1349. Leigh was seeking review of the Board's decision for a second time. *Id.*

[279] *Id.* at 685, 481 N.E.2d at 1356. The court set aside the Board's decision and remanded because it was unable to determine on which basis the Board's decision rested. *Id.*

[280] *Id.* at 679, 481 N.E.2d at 1353.

[281] *Id.* at 685, 481 N.E.2d at 1356.

[282] *Leigh II*, 399 Mass. at 559, 506 N.E.2d at 92.

to the Supreme Judicial Court of Massachusetts.[283] Leigh argued that the Nurse Practice Act violates the equal protection guarantees of the Constitution by restricting nurses from attending home births as lay midwives without similarly restricting lay midwives who are not nurses.[284]

In *Leigh II*, the court held that Leigh was not deprived of her constitutional right to equal protection of the laws.[285] The court reasoned that the classifications made by the statute could rationally further a legitimate state purpose.[286] The court analyzed the classifications of home birth versus hospital birth and lay midwife versus nurse-midwife in determining that Leigh was not deprived of her constitutional right to equal protection.[287] The court affirmed the Board's decision suspending Leigh's license to practice as a registered nurse.[288] Thus, in Massachusetts, lay midwifery is a legal but unregulated profession while nurse-midwives are regulated by the Board of Registration in Nursing and prohibited from attending home births. The status of a nurse, while not clear, seems to be analagous to that of a nurse-midwife.[289]

Thus, the Massachusetts Supreme Judicial Court has been reluctant to overturn the Massachusetts midwifery statute on the basis

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[283] *Id.*

[284] Brief for Appellant at 30, Leigh v. Board of Registration in Nursing, 399 Mass. 558, 506 N.E.2d 91 (1987) (No. 4173). *See Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93. Leigh argued that this treatment of the Nurse Practice Act created three classifications of midwives (nurse-midwives, lay midwives who are also nurses, and non-nurse lay midwives) in addition to obstetricians. Brief for Appellant at 30. Leigh additionally argued that the statute unconstitutionally infringed on pregnant women's due process rights and that the statute created an illegal restraint of trade under both federal and state law. *Leigh II*, 399 Mass. at 561–64, 506 N.E.2d at 93–95. This note does not address Leigh's last two arguments.

[285] *Id.* at 560–61, 506 N.E.2d at 93.

[286] *Id.* The court first postulated the encouragement of hospital births as a legitimate state purpose. The court secondly noted that the public expects a nurse "to have undergone a higher level of training than a lay midwife." For this reason the "State has a legitimate purpose in assuring a minimum level of training and competence in nurses licensed by the board so that consumers may rely on the board certification in making informed decisions about health care." *Id.*

The court concluded that the Nurse Practice Act, by requiring board certification of all nurses who practice as midwives, rationally furthers both legitimate state purposes. *Id.* The court did not specifically address, nor did this case raise, the issue of a nurse practicing as a lay midwife and not informing patients of his or her nursing status.

[287] *Id.* at 560–61, 506 N.E.2d at 93.

[288] *Id.* at 564, 506 N.E.2d at 95.

[289] In other words Massachusetts nurses must be certified as nurse-midwives to attend births as midwives and could not attend home births prior to June 1987. In June 1987 the Massachusetts legislature amended the Nurse Practice Act to allow nurse-midwives to attend home births. *See supra* note 206 and accompanying text.

of equal protection. In Massachusetts, a nurse who informs clients that she is a nurse may not practice lay midwifery. The Tennessee Court of Appeals indicated, in dicta, however, that it might invalidate a midwifery statute which allowed non-nurses to practice lay midwifery but prohibited nurses from practicing lay midwifery. In Tennessee, a nurse who does not inform his or her clients that he or she is a nurse may practice lay midwifery. Courts, therefore, have reached conflicting conclusions over a nurse's capacity to practice as a lay midwife. Because courts reach conflicting conclusions regarding a nurse's practice of lay midwifery, the status of a nurse practicing lay midwifery is unclear and nurses, for that reason, may refuse to function as lay midwives. At the same time the lay public may be left with individual lay midwives whose qualifications may be difficult to determine. Even though midwifery statutes may reach inconsistent results, courts have not invalidated midwifery statutes on equal protection grounds. State legislatures may need to regulate lay midwifery more rationally to provide safe birth options for women and infants.

III. Towards Consistent Regulation of Midwifery

Throughout history, midwives have been the usual childbirth attendants.[290] Obstetricians have gradually replaced midwives in the United States as the typical attendants at childbirth during the last seventy-five years.[291] Obstetricians generally support hospital births, arguing that they are safer than home births.[292] Because of this view, a decrease in the number of home births has correlated with the increase in the number of obstetrician-attended births.[293]

In recent years this trend has reversed. Increasing numbers of women are choosing home births, usually midwife-attended home births.[294] Because of these recent trends, states must address this trend in their regulatory schemes.

In regulating midwifery and home births, state legislatures need to consider that the relative safety of hospital births and home births is unclear.[295] Possibly as a result of this ambiguity, legislatures have enacted, and the courts have validated, a number of regulatory

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[290] Donegan, *supra* note 11, at 9. *See* Towler, *supra* note 71, at 12.

[291] *See supra* notes 118–133 and accompanying text.

[292] *See supra* note 6 and accompanying text.

[293] *See supra* notes 19–20 and accompanying text.

[294] *See supra* notes 9–10 and accompanying text.

[295] *See supra* notes 147–173 and accompanying text.

schemes.[296] Texas regulates both nurse-midwives and lay midwives, allowing both groups to attend home births.[297] In contrast, lay midwifery is legal but unregulated in Wisconsin, Tennessee, and Massachusetts.[298] Although nurse-midwives are regulated in these three states, until recently all three states prohibited nurse-midwives from attending home births.[299]

While the legal status of nurse-midwives is clear in Wisconsin, Tennessee, and Massachusetts, the status of nurses practicing lay midwifery is far from clear. In *Leggett*, the Tennessee Court of Appeals held that a nurse, who did not represent herself as a nurse, could practice lay midwifery without risking the loss of her nursing license.[300] The *Leggett* court indicated, in dicta, that revoking a nurse's license for the practice of lay midwifery might violate equal protection.[301] The Massachusetts Supreme Judicial Court in *Leigh II*, however, held that disciplining a nurse, who represented herself as a nurse, for functioning as a lay midwife at home births did not violate equal protection.[302] Thus, because Wisconsin, Tennessee, and Massachusetts do not regulate lay midwifery but regulate nurse-midwifery, a nurse practicing lay midwifery risks losing his or her nursing license.

Because courts have not invalidated regulatory schemes for midwifery, legislatures must address the irrational results produced by failing to regulate lay midwifery and by prohibiting nurse-midwives from attending home births. Such a regulatory scheme is irrational because it leaves women selecting home births with only

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[296] *See supra* notes 174–78, 250–89 and accompanying text.

[297] *See supra* notes 209–221 and accompanying text. Because the requirements to practice as a lay midwife differ from the requirements to practice as a nurse-midwife, a nurse might choose to practice as a lay midwife instead of as a nurse-midwife. Texas courts could interpret these statutes to allow a nurse this choice.

[298] *See supra* notes 185–208 and accompanying text.

[299] *See supra* notes 43–46 and accompanying text.

Although Massachusetts nurse-midwives may now attend home births, Wisconsin and Tennessee nurse-midwives still may not attend home births. Any unregulated person in Wisconsin and Tennessee, however, can attend a home birth as a lay midwife. Concurrently prohibiting nurse-midwives from attending home births reaches the illogical result of allowing people with debatable training and skills to attend home births while at the same time prohibiting professionals with training and skills from doing the same. In June 1987, the Massachusetts legislature changed this illogical result by amending the Nurse Practice Act to allow nurse-midwives to attend home births. 1987 Mass. Adv. Legis. Serv. 182 (Law. Co-op.). Wisconsin and Tennessee have yet to follow suit.

[300] 617 S.W.2d at 481. *See supra* notes 259–67 and accompanying text.

[301] 617 S.W.2d at 481.

[302] 399 Mass. at 560–61, 506 N.E.2d at 93. *See supra* notes 268–89 and accompanying text.

questionably qualified midwives. While the midwifery regulatory schemes of Wisconsin, Tennessee, and Massachusetts will pass constitutional scrutiny, these regulatory schemes cannot be justified merely on this basis. The Texas regulatory scheme for midwifery, especially the Texas lay midwifery statute, is a possible model for the regulation of midwifery.

Unlike Texas, the midwifery regulatory schemes of Wisconsin, Tennessee, and Massachusetts do not address the regulation of lay midwives. Because the regulatory schemes of Wisconsin, Tennessee, and Massachusetts are so similar, the *Leggett* and *Leigh II* cases raise serious questions about the legal status of nurses in these states who function as lay midwives outside of their nursing practice. These states regulate nurse-midwifery as a nursing specialty with certification requirements, such as education and experience, which are in addition to those requirements for a nursing license.[303]

In *Leigh II*, the midwife challenged the Massachusetts Nurse Midwifery Statute[304] as violative of the equal protection clause of the fourteenth amendment. Janet Leigh argued that although she represented herself as a nurse with obstetrical experience, she was practicing lay midwifery outside her nursing role.[305] She stated that to create three classifications of midwives[306] and prevent only those midwives with a nursing license from attending home births created an unfair classification.[307] Leigh argued that equal protection required the legislature to prohibit lay midwives from attending home births if it prohibits individuals licensed to practice nursing from attending home births.[308] She additionally contended that the legislature could not prevent lay midwives who are nurses from attending home births if lay midwives can attend home births without violating equal protection.

The Supreme Judicial Court of Massachusetts rejected Leigh's equal protection arguments. As a result, *Leigh II* created three potential classifications of midwives in Massachusetts. These classifications are lay midwives, nurse-midwives, and nurses practicing as

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[303] MASS. GEN. L. ch. 112, §§ 80C, 80D (1986); TENN. CODE ANN. § 63-7-207 (1986); WIS. STAT. ANN. § 33-339 (West 1988).

[304] MASS. GEN. L. ch. 112, §§ 80C, 80D (1986).

[305] *See supra* note 284 and accompanying text.

[306] These classifications are lay midwives, nurse-midwives, and lay midwives who practice outside their separate status as a nurse. Brief for Appellant at 30, Leigh v. Board of Registration in Nursing, 399 Mass. 558, 506 N.E.2d 91 (1987) (No. 4173).

[307] *Id.*

[308] *Id.*

lay midwives.[309] While the *Leigh II* court held that these classifications did not violate equal protection, it did not undertake a detailed constitutional analysis of Massachusetts' regulation of midwifery.[310] To determine whether the classifications of lay midwives created by *Leigh II* violate equal protection, it is necessary to determine if these classifications further a legitimate state purpose.[311]

The *Leigh II* court surmised two hypothetical purposes,[312] both of which seem to be legitimate. The first purpose is to protect the health and safety of its citizens. States regulate health care professionals, including nurses, to protect the health and safety of their citizens. Insuring that licensed nurses function within their state defined roles is a legitimate state objective. Prescribing requirements for education and experience prior to receiving a license to practice nursing and disciplining nurses who function outside their defined roles assure the public that licensed nurses possess at least a minimal level of competence.

The second set of purposes relate to the plausible state objective of encouraging hospital births. While studies evaluating the safety of home birth as opposed to hospital birth are far from conclusive,[313] the state could reasonably conclude that it should encourage hospital births until the safety issues are clearly decided.[314] Thus, a court or legislature could advance two conceivable, legitimate state purposes for the nurse-midwifery statute, ensuring the quality of licensed nurses and discouraging home births.

The next step in the equal protection analysis is to determine if a rational relationship exists between these legitimate state objectives and the methods the statute employs to achieve them.[315] Two arguments can be made in opposition to a rational relationship. The first is one of under-inclusiveness,[316] that the legislature prevents

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[309] It can also be argued that *Leigh* created only two classifications of midwives: those who are licensed nurses and those who are not.

[310] *See Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93.

[311] *See supra* notes 225–231 and accompanying text.

[312] No actual purpose is articulated in the nurse-midwifery statute itself or its legislative history. Some critics would argue that this fact alone invalidates the nurse-midwifery statute. *See supra* note 236.

[313] *See supra* notes 147–173 and accompanying text.

[314] The legislature prohibited nurse-midwives from attending home births prior to revision of the Nurse Practice Act in June 1987. One could question the political forces that enter into this decision: MDs, CNMs, and hospitals. The health care industry is alive and well in Massachusetts. It is both politically active and vocal.

[315] *See supra* notes 240–49 and accompanying text.

[316] *See supra* notes 243–45 and accompanying text.

nurses from attending home births and it does not similarly burden lay midwives. The second, and stronger argument, is one of over-inclusiveness,[317] that the legislature burdens a nurse practicing midwifery as a lay midwife in addition to burdening a nurse practicing midwifery as a nurse-midwife.

It is unlikely that a court, on the basis of under-inclusiveness, would invalidate a statute prohibiting nurse-midwives from attending home births while not similarly restricting lay midwives.[318] The United States Supreme Court has not imposed a requirement for a legislature to attack all aspects of a situation at once.[319] Rather, the Court has allowed legislatures to proceed one step at a time.[320] The Massachusetts legislature's goal may be to regulate all midwifery.[321] Regulating only nurse-midwives, therefore, is a step towards this goal. Thus, although the state may unfairly burden nurse-midwives in relation to lay midwives, such a regulatory scheme passes constitutional scrutiny under Supreme Court precedent.

The argument of over-inclusiveness, that the nurse-midwifery statute burdens a nurse practicing as a lay midwife in addition to burdening a nurse practicing as a nurse-midwife, is more likely to appeal to a court's sense of fairness.[322] In the *Leigh II* case the midwife, however, informed her patients of her status as a nurse with obstetrical training.[323] Because of this representation, Janet Leigh brought herself under the restrictions of the Nurse Practice Act.[324] The state of Massachusetts has a legitimate interest in ensuring that its nurses, holding themselves out as nurses, adhere to

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[317] *See supra* note 246.

[318] *See supra* note 243 and accompanying text.

[319] *See supra* note 244 and accompanying text.

[320] *See supra* note 245 and accompanying text.

[321] Additionally, the legislature reasonably could have concluded from Commonwealth v. Porn that midwifery was illegal in Massachusetts except as subsequently changed by statute. 196 Mass. 326, 82 N.E. 31 (1907). The legislature enacted the nurse-midwifery statute to allow nurses to practice in the expanded role of nurse-midwife. The legislature limited this practice to hospitals or licensed birth centers. *See supra* notes 204–06. Thus, the legislature impliedly determined that nurse-midwives, the only legal midwifery, could not attend home births.

Alternatively, the legislature could have concluded that it was unnecessary for it to address the issue of home births attended by lay midwives if there were a relatively insignificant number of lay midwives within Massachusetts.

[322] *See supra* note 246.

[323] Leigh v. Board of Registration in Nursing, 395 Mass. 670, 673, 481 N.E.2d 1347, 1349 (1985) (*Leigh I*).

[324] MASS. GEN. L. ch. 112, §§ 74–81C (1986).

the rules and regulations of the profession of which they are licensed members.[325]

Articulating a legitimate state purpose for distinguishing between lay midwives and lay midwives who practice an additional profession, nursing, independent of their lay midwifery practice is far more difficult.[326] While the *Leigh II* court intimated that these classifications would pass constitutional scrutiny,[327] the *Leggett* court, in dicta, expressed its doubt.[328] One possible state purpose might be to discourage consumers from using lay midwives as birth attendants. The legislature could conclude that lay midwives generally are not adequately trained. Allowing nurses to function as lay midwives, arguably, would give the public a false sense of confidence in the skills of lay midwives. Alternatively, the legislature could decide that because nurses can function as midwives, the role of a nurse-midwife is too similar to the role of a lay midwife to allow nurses to function as lay midwives. Allowing a nurse to function as a lay midwife merely allows, arguably, a nurse to circumvent nursing regulations. Thus, although articulating a legitimate purpose for distinguishing between lay midwives who are nurses and lay midwives who are not nurses is difficult, one can postulate two arguable purposes for this distinction which rationally relate to these classifications.

A midwifery regulatory scheme which regulates nurse-midwives but fails to regulate lay midwives, as applied to the facts of the *Leigh* cases, passes minimum rationality. A court could surmise two legitimate state purposes for such a regulatory scheme. Additionally, a court could postulate several reasonable relationships that could exist between the legislature's purpose and the midwifery classifications adopted.

Therefore Massachusetts, prior to the June 1987 amendment to the nurse-midwifery statute, treated midwife attendance at home births in a variety of ways, depending on which of the previous classifications applied to the midwife. A case analogous to *Leigh II* arising in Wisconsin or Tennessee might reach similar results be-

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[325] Leigh v. Board of Registration in Nursing, 399 Mass. 558, 560–61, 506 N.E.2d 91, 93 (1987) (*Leigh II*).

[326] *See* Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476, 480 (1981) (dictum).

[327] *Leigh II*, 399 Mass. at 560–61, 506 N.E.2d at 93.

[328] *Leggett*, 612 S.W.2d at 480. One can distinguish these cases factually. In *Leigh II*, the nurse told her midwifery clients that she was a nurse. In *Leggett*, the nurse did not disclose her nursing status to her clients and therefore was not subject to nursing regulations.

cause Wisconsin and Tennessee regulate midwifery like Massachusetts did prior to June 1987. As a result of the *Leigh II* decision, a nurse-midwife clearly could not attend a home birth prior to June 1987. A lay midwife could attend any home birth, with or without training, with or without education, and without any regulations protecting public health and safety. A lay midwife who was a nurse, and informed her clients of that fact, could not attend home births. Thus, Wisconsin and Tennessee could adopt the rationale of *Leigh II* resulting in three classifications of midwives, because they regulate midwifery similar to the way Massachusetts regulated midwifery prior to June 1987.

While a legislature's method of achieving its plausible objectives by creating three classifications of midwives is rational, a legislature's wisdom in doing so is highly debatable. Prohibiting nurses from practicing lay midwifery in addition to nursing is unfair to both the public and nurses who wish to practice as lay midwives. Allowing lay midwives unrestricted practice in the home birth environment, without any assurance as to their training and education, is a poor way to discourage home births[329] or the use of lay midwives.

Wisconsin, Tennessee, and Massachusetts need to recognize and regulate lay midwifery, in addition to nurse-midwifery. The regulatory schemes of Wisconsin, Tennessee, and Massachusetts, as they now exist, do not indicate for what midwifery practices their boards of nursing can revoke a nurse's license. These regulatory schemes do not indicate clearly if a nursing board can revoke a nurse's license for practicing lay midwifery without informing clients of his or her concurrent status as a nurse or if a nursing board can revoke a nursing license only if the nurse informs lay midwifery clients of his or her status as a nurse.

Because the status of nurses concurrently practicing unregulated lay midwifery is unclear, the *Leggett* and *Leigh* courts may have

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[329] Rantz, *supra* note 2, at 43.

> Regardless of our feelings as physicians, the return to out-of-hospital birth occurring in this country cannot be stopped. Some third-party carriers are already encouraging and reimbursing out-of-hospital births and lay midwives because they are less expensive and very safe. Consumer groups are becoming better organized and more vocal . . . .
>
> Already the vast majority of home births in this country are attended by lay midwives, not nurse-midwives . . . . Many of these are skilled, dedicated people who have had extensive training and experience. However, it is frequently impossible for midwives to to get the kind of training and professional support they need.

Id.

determined whether the board of nursing could discipline nurses practicing midwifery based upon what the nurses represented to their lay midwifery clients. In *Leggett*, the nurse did not represent herself as a nurse.[330] Therefore, the Board of Nursing could not discipline her for practicing lay midwifery.[331] In *Leigh*, the nurse informed her clients that she was a nurse with obstetrical experience.[332] Because she represented herself as a nurse, the Board of Registration in Nursing had jurisdiction to discipline Leigh.[333]

Legislatures need to clarify the status of nurses practicing lay midwifery. In regulating lay midwifery, legislatures need to determine explicitly if nurses can practice as lay midwives. If legislatures fail to make this provision, courts will continue evaluating a nurse's capacity to practice lay midwifery on the basis of what he or she represents to clients. Clearly, this is unpredictable and is not the best way to ensure that women who choose home births have access to qualified birth attendants.

Legislatures need to provide women who choose home births with a way to determine the qualifications of lay midwives. The regulatory schemes of Wisconsin, Tennessee, and Massachusetts do not protect consumers of midwifery adequately because these regulatory schemes fail to provide them with a means to distinguish qualified lay midwives from unqualified persons. Legislation for lay midwifery should provide both competency standards and a means to identify qualified lay midwives.

Legislatures need to enact legislation regulating lay midwives because increasing the attendance of trained midwives at home births may, arguably, be a safer and cheaper way to provide adequate maternity care. Other countries have integrated lay midwives into modern obstetrical care with excellent mortality and morbidity results.[334] Legislatures should foster research of alternative birth practices by enacting appropriate regulatory legislation and funding studies. Thus, legislatures should address and regulate lay midwifery to clarify the status of nurses functioning as lay midwives, to provide healthcare consumers with a means to evaluate lay midwives, and to aid in the safety determinations of home birth and midwife-attended births.

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[330] *Leggett*, 612 S.W.2d at 480.

[331] *Id.* at 481.

[332] Leigh v. Board of Registration in Nursing, 395 Mass. 670, 673, 481 N.E.2d 1347, 1349 (1985) (*Leigh I*).

[333] *See id.* at 564, 481 N.E.2d at 1356.

[334] *See supra* notes 158–59 and accompanying text.

An alternative to regulating lay midwives in the home birth environment would be to outlaw lay midwifery and home births entirely.[335] Due to the growing demand for midwife-attended home births, this alternative may have more serious repercussions than merely addressing the situation directly by regulating lay midwives. Making home births illegal might cause mothers desiring a home birth to obtain one illegally from attendants with questionable qualifications. Such a statute would be difficult to enforce. Mothers desiring a home birth already defy established authorities and the majority of their peers when they select home as the place to give birth to a child.[336] The risks to mothers and infants are far greater if states deny them safe alternatives to hospital birth.

Legislatures concerned with the safety of their constituents should recognize and regulate lay midwives, many of whom practice professionally, and allow nurse-midwives to attend home births. Because of the inconclusive data on the relative safety of home birth versus hospital birth and the element of individual choice involved, states can best protect the health and safety of their citizens by providing a regulatory framework.[337] Regulation of lay midwives

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> There are . . . practical arguments against a statute outlawing home birth. The consequences of such a law might well be worse than the risks to the unborn life that the law would be designed to protect. As laws prohibiting abortions drove women to seek help illicitly, so a law banning home births would drive that practice underground . . . .
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> Even now, with no laws banning home birth on the books, couples who engage in home births are defying established medical authority. Mothers who choose this option must surmount many obstacles to obtain competent attendants and adequate hospital backup. If laws were passed, it is foolish to believe that everyone would obey them. Indeed, such a law would be impossible to enforce, because mothers desiring home birth would not inform a physician or go to the hospital. Such a law would certainly decrease the availability of trained home birth attendants, however. And since unattended home birth is ten times as risky as home birth attended by a professional, the law might decrease the number of home births but increase the absolute mortality rate of both infants and mothers.

Hoff, *supra* note 2, at 25.

[336] *Id.*

[337] *Id.*

> [O]ur moral institutions do not yield a conclusive answer on the assessment of risks versus benefits of home birth. The essential conflict is twofold. First, we lack data about the relative risks in home versus hospital birth. This deficiency can in principle be corrected by the proper research. Second, in weighing values or ethical principles in tension — the sanctity of life versus the quality of life — an ethical dilemma is created that cannot be resolved simply by exposing

should encompass education, training, practice standards, registration of lay midwives, and disciplinary procedures, and should specify whether or not nurses may function as lay midwives outside of their license to practice nursing.

The Texas lay midwifery statute provides an example of a comprehensive regulatory scheme.[338] This statute provides standards for education and training of lay midwives, a method to identify qualified lay midwives, guidance as to acceptable practices a lay midwife may perform, and disciplinary procedures for lay midwives.[339] The Texas legislature has mandated a study of the effectiveness of this statute.

Texas, moreover, allows nurse-midwives to attend home births.[340] Allowing nurse-midwives to attend home births eliminates the irrational result of only allowing unregulated, questionably trained individuals to attend home births when trained and qualified nurse-midwives exist who might be willing to attend home births if permitted to do so by statute. Therefore, Texas provides an example of a regulatory scheme which allows nurse-midwives to attend home births and comprehensively regulates lay midwifery. Such a regulatory scheme best protects the health and safety of mothers who are seeking a home birth, and their infants.

CONCLUSION

Home births and midwifery have experienced a revival in the recent past. States are beginning, and should continue, to regulate these areas. Legislatures can best protect the safety of mothers and infants in the home birth environment by allowing them access to qualified professionals as attendants. Midwives can be safe and ef-

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> invalid arguments or clarifying facts. Therefore, no sweeping declaration is possible with respect to the ethics of home births; the decision for or against must be made on a case-by-case basis. . . .
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> Home birth does not represent a clear and present danger to the common good.

Id.

[338] *See supra* notes 209–221 and accompanying text.

[339] *Id.*

[340] *See supra* notes 209–221 and accompanying text. This statute, however, does not specify whether or not nurses may practice as lay midwives as opposed to nurse-midwives. The Texas courts have not addressed the issue of a nurse practicing as a lay midwife. The results reached by the *Leggett* and *Leigh* courts could occur in Texas. Thus, while Texas regulates lay midwifery, it has not indicated whether or not a nurse may practice as a lay midwife.

fective birth attendants. Regulation of lay midwives, in addition to nurse-midwives, will provide the public with a means to determine the qualifications of the attendants they select for home births. Regulation of lay midwives should encompass education, training, practice standards, registration of lay midwives, and disciplinary procedures, and should specify whether or not nurses may function as lay midwives outside of their license to practice nursing. Banning home births will not prevent the selection of home births, but will only increase the risks associated with them. Recognition and regulation of all aspects of midwifery is long overdue.

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