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NOTE

BORN BY THE WOMAN, CAUGHT BY THE MIDWIFE: THE CASE FOR LEGALIZING DIRECT-ENTRY MIDWIFERY IN ALL FIFTY STATES

Sarah Anne Stover†

INTRODUCTION

To many Americans, childbirth is traditionally perceived as a physician attended event that occurs in a hospital setting. Although this is the dominant view of obstetric care in the United States, it is not the prevailing view of birth in most parts of the world. In nearly all other developed countries, midwives assume the central role in the management of normal pregnancy and birth. While midwife-attended births are the norm elsewhere, the use of a midwife as a birth attendant or the choice of a home birth are often deemed archaic practices in the United States, where most deliveries are attended by specialist obstetricians in hospitals.

Although this idea of a medically controlled birth remains the majority view in twenty-first-century America, current research suggests that traditional notions of childbirth are evolving beyond the physician and hospital to include births attended by midwives, outpatient birth-

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ing centers, home births and other alternative birthing practices. Research studies also identify changing trends among childbearing women’s preferences regarding birth. In 2006, 7.4% of all births in the United States were attended by certified-midwives and certified nurse-midwives. Statistics also indicate that the number of American women seeking a non-medical, more natural approach to childbirth is rapidly increasing. While only 1% of American women reported giving birth at home, a pilot study of mothers delivering in hospitals determined that 20% of those mothers would have preferred a non-hospital delivery if medical backup was readily available.

In response to these trends, birthing centers are opening across the country to offer the natural birth experience with the comfort of medical backup. Most hospitals are also adjusting obstetric policies to accommodate women’s requests during the birthing experience.

4 A birthing center is an outpatient facility subject to state standards, accreditation and regulation, which provides a complete network of maternity and women’s health services by qualified practitioners. Birth centers are typically staffed by midwives, but provide access to obstetric specialists. Women labor and deliver in the birthing center’s family-oriented home-like setting under the attentive care of a health practitioner, but transfer to a near-by hospital is available if the need arises. See Birth Center FAQ’s: What is a Birth Center?, AMERICAN ASSOCIATION OF BIRTH CENTERS, http://www.birthcenters.org/birth-center-faq/what-is-a-birth-center/index.php (last visited Jan. 17, 2011).


6 Id.; see also Hafner-Eaton & Pearce, supra note 2, at 814.


8 See Hafner-Eaton & Pearce, supra note 2, at 814 (citing Hafner-Eaton, Using Psycho-Social and Medical Factors to Model Birth Outcomes, Presentation at the Association for Health Services Research Conference (June 12, 1994)).


10 See Hilda J. Spear, Policies and Practices for Maternal Support Options During Childbirth and Breastfeeding Initiation After Cesarean in Southeastern Hospitals, 35 J. OBSTETRIC, GYNECOLOGICAL, & NEONATAL NURSING 634, 640 (2006); see also Labor and Delivery: Caring for Moms and Babies Like No One Else Can, UNIV. HOSP. OF CLEVELAND MACDONALD WOMEN’S HOSP., http://www.uhhospitals.org/macwomen/OurServices/ByDivision/DivisionofGeneralObstetricsandGynecology/LaborDelivery/tabid/1151/language/en-US/Default.aspx (last visited Jan. 30, 2011) (advertising “in addition to traditional deliveries, UH MacDo- nald Women’s Hospital offers midwifery delivery, water births and doula services.”). Hillcrest Hospital, a Cleveland Clinic Hospital, advertises that “the nursing and pro-
As birthing practices evolve, social discourse about the propriety of mainstream birthing ideologies versus alternative birthing practices continues. Substantial controversy exists among health care professionals and the public over what constitutes optimal management of pregnancy and childbirth. The debate is especially intense for healthy women with low-risk pregnancies, where few medical complications are expected.

Attention has also turned to the legality of some birthing options. In 2008, the Missouri State Supreme Court sparked a century-old debate about the legal status of midwives in the United States and the midwife’s role in the American healthcare system. The controversy centered on a specific type of midwife: the direct-entry midwife. Direct-entry midwives are midwives that enter directly into midwifery education and practice rather than entering through the discipline of nursing. The Missouri Court reversed the decision of a lower court that had invalidated a statute legalizing the practice of midwifery. Because the court decided the case on procedural issues, the midwifery practice issue remained unsettled.

The Missouri decision resurrected an age-old controversy about whether direct-entry midwives may legally provide services to women professional staff can accommodate your birthing preferences and needs by working closely with your private obstetrician and/or midwife.”

Feminist Staff can accommodate your birthing preferences and needs by working closely with your private obstetrician and/or midwife.”


Rosenblatt et al., supra note 3, at 344.

Id. Conversely, a high-risk pregnancy is “any pregnancy in which a medical factor, maternal or fetal, may adversely affect the outcome of pregnancy.” This includes a wide array of conditions including maternal pre-pregnancy medical complications, pregnancy-induced medical complications, fetal complications, and labor complications. Rachel Levy-Schiff et al., Maternal Adjustment and Infant Outcome in Medically-Defined High Risk Pregnancy, 38 DEV. PSYCHOL. 93, 93 (2002).

See Mo. State Med. Ass’n v. Missouri, 256 S.W.3d 85, 86 (Mo. 2008).

See id. In Missouri State Medical Association, professional medical groups, including the Missouri State Medical Association, challenged the validity of a statute legalizing the practice of midwifery. Id. at 86-87. Successful invalidation of the statute would ultimately prevent all midwives except for “licensed” midwives from practicing midwifery. Effectively, invalidation of the statute would prohibit direct-entry midwives from legally practicing their profession and only allow certified-nurse midwives to practice in Missouri.


Mo. State Med. Ass’n, 256 S.W.3d at 89.

Id. (holding that the medical association lacked standing to challenge the validity of the statute that legalized the practice of midwifery).
in the United States. Major issues in this debate involve the competence, regulation and scope of practice of midwives. Questions include: Should direct-entry midwives be legally recognized as legitimate birth attendants? What is the direct-entry midwife’s scope of practice? Who is ultimately responsible for regulating the direct-entry midwife?

In the United States, direct-entry midwives are regulated by state legislatures. Each state has the power to enact laws that protect the public’s health, safety and welfare, and may permit or prohibit direct-entry midwifery. Forty-one states permit direct-entry midwifery. However, nine states and the District of Columbia continue to prohibit direct-entry midwifery either by statute, judicial interpretation or overly restrictive scope of practice laws.

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19 The states that prohibit direct-entry midwifery through licensure, certification, permit, judicial interpretation, statutory interpretation or non-regulation are Alabama, Illinois, Indiana, Iowa, Kentucky, Maryland, North Carolina, Pennsylvania, South Dakota, and the District of Columbia. See ALA. CODE § 34-19-3 (LexisNexis 2010) (explicitly prohibiting direct-entry midwifery); D.C. CODE § 7-751.01 (LexisNexis 2010) (excluding direct-entry midwives from definitions of health care providers); 225 ILL. COMP. STAT. ANN. 60/3 to -4
A prohibition on direct-entry midwifery is a legitimate function of a state’s power to license and regulate health care professionals. Nevertheless, the use of this legislative power must be delicately balanced against an individual’s constitutional right to privacy in healthcare decisions, specifically, the legal interests of parents to choose an attendant for the birth of their child. States that prohibit midwifery deny pregnant women the full range of birthing options. The essential question is: by limiting women’s access to direct-entry midwives, are states meeting their goals of ensuring public health and welfare?

This Note recognizes that state legislatures have enormous powers to enact laws that protect public safety and health. It also acknowledges that courts are generally deferential to state legislative decisions concerning health regulations. Thus, challenging states’ decisions to prohibit direct-entry midwifery is legally difficult. Nevertheless, it is time to question the sensibility of prohibiting direct-entry midwifery.

This Note posits that state legislatures that completely prohibit direct-entry midwifery are abusing licensing powers because the legislatures’ prohibitions are not rationally justified by the health outcomes of mothers and babies. Statutes that prohibit direct-entry midwifery are over-expansive because states could instead license and regulate direct-entry midwives. Further, research suggests that the statutes fail to serve the public health interest and, in actuality, undermine public health. Because the statutes are not rationally related to a legitimate state goal, they should no longer withstand constitutional scrutiny under the 14th Amendment.

This Note also argues that pregnant women should retain rights to autonomy in medical decisions and rights to bodily integrity throughout their entire pregnancy. States that prohibit direct-entry midwifery unnecessarily limit patient choice by eliminating alternative birthing options for pregnant women and reduce women’s access to safe, affordable woman-centered health care. Because the midwifery prohibi-
tion threatens the exercise of important rights, careful evaluation of the state’s legislative purpose is warranted under the 14th Amendment.

Part I of this Note details the origins of midwifery, traces the development of midwifery in the United States and discusses the current status of midwifery throughout the fifty states. This section also differentiates the midwifery model of care from the medical model of care.

Part II explores the statutory mechanisms that states use to prohibit direct-entry midwifery. Then, Part II details women’s and infants’ health outcomes during midwife-assisted birth, and midwives’ contributions to public health. Part II concludes that states that prohibit direct-entry midwives are irresponsibly and unwisely using state licensing powers.

Because the refusal to license direct-entry midwives deprives or reduces pregnant women’s access to legally practicing midwives, Part III focuses on pregnant women. This section evaluates the interplay between pregnant women’s rights under the 14th Amendment, states’ interests in preserving the health of fetuses, and state regulation of birth attendants. Part III discusses cases that posed due process challenges to state legislation and explains why women’s due process challenges have been unsuccessful. I argue that courts inappropriately draw parallels between women seeking abortion and women choosing direct-entry midwives as birth attendants.

Part IV revisits the safety and efficacy of midwifery discussed in Part II and ties it together with women’s constitutional interests discussed in Part V. After critically weighing state and maternal interests, Part IV concludes that the state statutes prohibiting midwifery cannot withstand constitutional scrutiny under the 14th Amendment because the statutes are not rationally related to a legitimate state goal.

Finally, Part V argues that since legislatures are abusing licensing powers and pregnant women should have access to midwives, states that currently prohibit direct-entry midwives should license and regulate the midwives. This Part proposes legislative changes that would create a maternity care system where women in any state could choose a licensed midwife as the central provider for a normal, low-risk pregnancy, and obstetricians would remain the primary providers for abnormal, complicated pregnancies.

I. THE HISTORY, CURRENT STATUS AND MODEL OF MIDWIFERY

In order to understand the current status of midwifery in the United States it is useful to examine how midwifery developed. Many of the issues that involve and affect contemporary midwives evolved
through centuries of struggle. Midwifery, an ancient profession, survived a decline in professional recognition and virtual elimination in the United States during the early 1900s. Nevertheless, midwifery endured through the middle of the twentieth century, and finally reemerged in the latter half of the century with a grassroots women’s movement. During this renaissance, midwives have continued to work towards greater practice recognition and professional legitimacy.

A. The Origins of Midwifery in the United States

Midwifery is one of the world’s oldest professions. References to women who cared for other women during labor are found in the writings of Hippocrates and the Bible. The English word “midwife,” literally meaning “to be ‘with woman’ during childbirth,” was used as early as 1303. Women learned the midwifery trade by apprenticeship as women supported, comforted and encouraged one another in childbirth. After a woman developed skills and knowledge by observing a number of deliveries, she would pass her knowledge on to a younger generation of women.

Midwives were responsible for nearly all pregnancy healthcare in the United States for nearly 250 years. Most midwives were illiterate immigrants who informally trained in Europe, Britain and West Africa. Although midwives’ preparation varied and they practiced without any form of regulation, midwives were respected members of their communities.

Childbirth in the new American colonies was a communal event with female friends, relatives, neighbors and midwives all in attendance. Birth was technologically simplistic because drugs and sur-

25 Id. at 3.
26 Id. at 4.
27 Id.
28 Id. at 17-18.
29 Id. at 11. West African midwives known as “granny midwives” came to the colonies as slaves. They mainly provided pregnancy care to slave women on southern plantations. Id. at 18.
30 Id.
gical instruments were unavailable in the early eighteenth century.\textsuperscript{32} Thus, physicians in the American colonies could not offer more advanced care than midwives.\textsuperscript{33} This developed a “system of cooperation” and “professional courtesy” between midwives and physicians.\textsuperscript{34}

This cooperative relationship between physicians and midwives began to deteriorate in the latter portion of the eighteenth century. American physicians training in Britain brought the idea of expanding their role in the childbirth process to the United States.\textsuperscript{35} American physicians soon learned that obstetric care was essential to a successful general medical practice.\textsuperscript{36} Although most physicians, like midwives, were trained through experiential apprenticeships and not medical schools, many began to assume that physicians had formal training in obstetrics.\textsuperscript{37} With the advent of the forceps and opium,\textsuperscript{38} physicians could offer a new approach to obstetrical care.

Some midwives attempted to resist the new male interest in obstetrics. “[M]otivated by moral outrage about the growing involvement of men in the physical care of women,” Samuel Gregory established the first midwifery school in the United States.\textsuperscript{39} The Boston Medical Society criticized the school, claiming that women were not suited to the tensions of medical practice.\textsuperscript{40} Thirty years later, facing financial difficulty and social pressure, the midwifery school closed.\textsuperscript{41} Similar efforts to improve the education of midwives and implement licensing procedures failed.\textsuperscript{42}

Meanwhile, medicine increasingly became professionalized. By 1859 obstetrics was officially recognized as a specialty by the American Medical Association, and physicians began to control access to obstetrics by encouraging legislatures to pass state medical laws re-

\begin{itemize}
  \item[32] \textit{Id.} at 54.
  \item[33] \textit{Id.}
  \item[34] See \textit{id.} at 61 (observing that “female healers move[d] in and out of sick-rooms unannounced, as though their presence there were the most ordinary thing in the world . . . ”)
  \item[35] ROOKS, supra note 24, at 19.
  \item[36] \textit{Id.}
  \item[37] \textit{Id.}
  \item[38] \textit{Id.}
  \item[39] \textit{Id.}
  \item[41] Cazalet, \textit{supra} note 40; ROOKS, supra note 24, at 19.
  \item[42] ROOKS, \textit{supra} note 24, at 19. Instruction at other newly opened midwifery schools was “compromised by financial instability, limited access to clinical experience for students, and lack of a sound theoretical base for the profession.” \textit{Id.}
quiring licensure for practice. Because there were still so few obstetrical physicians, it was impractical to completely outlaw midwives at this time. Midwives continued to practice by predominantly attending to poor women for whom physicians refused care. By the early 1900s, physicians attended half of births in the United States, but 95% of women still gave birth at home.

B. The Golden Age of Medicine—A Campaign to Eliminate Midwives

By the late nineteenth century, affluent pregnant women who believed childbirth was safer and less painful in physicians' hands joined obstetricians in a campaign to eliminate the American midwife. In areas where physicians were readily available to provide obstetric care, physicians lobbied to prevent midwives from practicing at all. Midwives ineffectively countered this campaign for their elimination. As part of a profession dominated by females, midwives maintained little political power. It was easy for physicians to attack midwifery by characterizing midwives as untrained and incompetent.

Meanwhile, social and economic conditions of the 1900s supported the transition to childbirth in hospitals. In this new birth setting, obstetric focus changed from responding to problems to preventing any possible problems through physician interventions. Soon, delivery interventions, such as forceps-assisted birth, surgical fetal extraction and pharmaceutical intervention, became routine.

Still, the "midwifery problem" persisted. In an attempt to improve obstetrics' standing within professional medicine, physicians pushed

43 Id. at 21.
44 Id.
45 Id.
46 Id. at 22.
48 See Hafner-Eaton & Pearce, supra note 2, at 815-16; see also Rooks, supra note 24, at 22-23.
49 Rooks, supra note 24, at 22.
50 Id. at 24.
51 Id. at 25. Some physicians went further and characterized midwives as being "poor, black, immigrants, dirty, illiterate, untrained, ignorant, immoral, drunken, unprincipled, overconfident, superstitious, callous" and "rough relics of barbarism." Id.
52 Id.
53 Id. at 26.
54 Id. at 25-26.
to outlaw midwifery outright.\(^{55}\) Public health officials proposed a system that would educate and regulate midwives,\(^{56}\) but some medical boards told legislatures that it would be too dangerous to license midwives.\(^{57}\) This notion persisted even though data established midwifery’s safety.\(^{58}\) The White House Conference on Child Health and Protection study in 1925 concluded that midwives “surpass the record of physicians in normal deliveries.”\(^{59}\) The study attributed the favorable statistics to the fact that midwives did not employ medical procedures to hasten delivery that ultimately harmed the mother.\(^{60}\)

By 1950, 88% of births occurred in the hospital, with obstetricians attending 80% of all deliveries.\(^{61}\) One scholar notes that in such a short amount of time, obstetricians

enticed [most women]...into [hospitals] for childbirth, forced [on women] a medical model of birth that has never been proven safe or beneficial, raised the price of services which have diminished in quality and quantity, and lobbied state legislatures for laws that would require [women] to submit to their exclusive control during pregnancy and childbirth.\(^{62}\)

C. A Movement to Reform Maternity Care

By the middle of the twentieth century, the number of American direct-entry midwives declined sharply,\(^{63}\) suggesting an end to the direct-entry midwife in the United States. However, in the 1960s and 1970s a grassroots movement premised on the idea of “natural childbirth” and “prepared childbirth” began.\(^{64}\) In reaction to what some

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\(^{55}\) Id. at 26.

\(^{56}\) Id.

\(^{57}\) Id.

\(^{58}\) Id.

\(^{59}\) Id. at 29-30.

\(^{60}\) Id.


\(^{62}\) Suzanne Hope Suarez, Midwifery is Not the Practice of Medicine, 5 Yale J.L. & Feminism 315, 315 (1993).


\(^{64}\) Id.; Mosby’s Pocket Dictionary of Medicine, Nursing and Allied Health 783 (3rd ed. 1998) (“Natural childbirth” is labor “accomplished by a mother with little or no medical intervention” and usually requires among other things, normal gestation, physical and emotional preparation and “constant and intensive support of the mother during labor and delivery”) [hereinafter Mosby’s Pocket Dictionary]. Labor and Delivery Preparing, MJ Bovo,
people perceived as overly medicalized hospital births, women began seeking home births, which they associated with more personalized, supportive care. Since physicians rarely attended home births, the midwife re-emerged.

Women and midwives organized local study groups that read medical literature and shared personal experiences. Eventually, local organizations united and formed midwifery schools, birth centers, and state and national associations. What began as a disjointed "grassroots movement responding to consumer demand" gradually formed professional bodies with money, political power and national identities.

D. Current Legal Status of Midwives in the United States

Since the re-emergence of midwifery in the 1960s and 1970s, midwives have strived to re-establish themselves as legitimate professionals. Because the types of midwives vary, individual state statutes determine the legal status of midwives. American midwives enter the profession from one of two general directions.

The first type of midwife is the certified nurse-midwife (CNM). The practice of nurse-midwifery was established in the United States in the 1920s. Nurse-midwives first obtain basic nursing education and then complete post-graduate education in the midwifery specialty. Nurse-midwives practice legally in all fifty states, but usually only attend births in the hospital setting.

http://www.mjbovo.com/Pregnancy/LDPrep.htm ("Prepared childbirth means teaching and understanding methods to cope with normal childbirth and understanding the natural sequence of events in labor and delivery.") (last visited Nov. 13, 2010).

Myers-Ciecko, supra note 63, at 384.

Id.

Id. at 384-85.

Id. at 385.

Examples of professional midwives associations include Midwives Alliance of North America, Midwifery Education Accreditation Council, National Association of Certified Professional Midwives, American College of Nurse-Midwives, and many more. Links to individual informational websites are available at http://mana.org/links.html.

Kennedy et al., supra note 21, at 204.


Id.

Kennedy et al., supra note 21, at 204.

The second way to enter into midwifery is directly, through apprenticeship with a midwife or by a structured midwifery educational program. Prior to 1994, states that allowed direct-entry midwives to practice legally had individual licensure requirements and varying standards of practice. Because state regulation of the direct-entry midwife was so varied, the professional associations of direct-entry midwives recognized the need to create national education and certification standards. Finally, in 1994, direct-entry midwives could obtain national certification through the North American Registry of Midwives (NARM) and were designated as certified professional midwives (CPMs). Since the advent of the CPM certification, most states that regulate direct-entry midwives require midwifery candidates to take the NARM exam and complete the NARM certification process prior to receiving a license by the state. Only a few states develop their own certification standards and exams.

E. Differentiating the Medical Model of Care from the Midwifery Model of Care

The medical model of care and the midwifery model of care represent two separate approaches to the care of pregnant women, the management of a woman’s labor, and the delivery of an infant. Although the models are separate and distinct, the models can be complimentary and each can contribute to the management of pregnancy.

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75 Kennedy et al., supra note 21, at 204.
77 The Midwives Alliance of North America laid the groundwork for national education and certification standards when it developed a national certifying exam for direct-entry midwives, created a national registry of direct-entry midwives, published a statement of values and ethics guiding professional conduct of the direct-entry midwife, developed core competencies for the direct-entry midwife and began collecting data for research. See id.
78 Kennedy, Rousseau, & Low, supra note 21, at 204. The North American Registry of Midwives (NARM) created the certification mechanism and The Midwifery Education Accreditation Council (MEAC) established requirements for accreditation of direct-entry midwifery schools that were recognized by the US Department of Education. CPM Issue Brief, supra note 76.
79 See id.
80 See id.
The medical model is based on an allopathic\(^2\) approach to medicine and focuses on the pathologic potential of pregnancy and birth.\(^3\) Obstetricians' primary focus is on diagnosis and treatment of pregnancy complications.\(^4\) This desire to identify and treat complications early has led obstetricians to approach birth as though it is a naturally risky physiologic process with grave risks that need to be managed by a physician, in a hospital, where emergency equipment and procedures are accessible.\(^5\) In treating pregnancy as pathologic, obstetricians sometimes disregard the distinction between high-risk and low-risk pregnancies, and instead treat all women as though an unexpected complication can happen at any time.\(^6\)

Because obstetricians believe that complications can happen at any time, the medical model prepares for the worst scenario.\(^7\) Intravenous lines are routinely established in all laboring women, food and liquids are withheld, and mechanical monitors are used.\(^8\) The medical model uses narrow criteria and time frames to measure what is normal and suggests intervention when a woman's labor falls outside of the criteria, even if there is no physiologic evidence that the mother or infant are doing poorly.\(^9\) Thus, interventions are applied not based on evidence of negative outcomes, but instead as preventive measures.

This approach to pregnancy is well suited to the management of pregnant women that are considered high-risk. Complications are diagnosed and treated quickly, the latest medical technology is utilized, and the surgical skills of obstetricians are employed.

Obstetricians in the medical model of care also perceive themselves as the key decision-makers during labor and delivery.\(^10\) They actively manage labor and delivery through technologies that speed up labor, they push a fetus through the birth canal, or they pull a fetus out of the mother.\(^11\) But, obstetricians do not stay with women throughout

\(^{2}\) Allopathy is a school of medical thought "in which disease . . . is treated by creating an environment that is antagonistic to the disease or condition." MOSBY'S POCKET DICTIONARY, supra note 64, at 49.

\(^{3}\) Rooks, supra note 81, at 370.

\(^{4}\) Id. at 370-71.

\(^{5}\) Hafner-Eaton & Pearce, supra note 2, at 817; see also Rooks, supra note 81, at 371.

\(^{6}\) See Rooks, supra note 81, at 371.

\(^{7}\) Id.

\(^{8}\) Id.

\(^{9}\) Id. at 373.

\(^{10}\) Id. at 372.

the labor and delivery. Instead, they rely on nursing assistants and machines to monitor the progression of labor. Yet most physicians perceive themselves as “delivering” babies because obstetricians are usually present at the moment of birth.

In contrast, midwives are experts in normal pregnancy and low-risk birth. Midwives view birth as a natural process that should be treated as normal until there is evidence of a problem. Midwives do not “deliver” babies, but instead attend the laboring woman and “catch” the baby. This recognizes that the pregnant woman’s body is the mechanism that actually delivers the baby.

The midwife recognizes the woman as the primary decision-maker. Since the woman is the primary actor, the midwife’s role is to identify problems, provide information, give options and support the woman to make the best decisions.

Midwives often have a more holistic approach to pregnancy care and birth than physicians. Midwives do not allow the possibility of complications “to preempt all other values associated with the woman’s experience of bearing and giving birth to a child.” A midwife wants to know a woman’s expectations of pregnancy and delivery, her perceptions, beliefs, opinions, questions, worries, satisfactions, dissatisfactions, comforts, discomforts and desires among many other things. Understandably, the midwifery model of care is time-intensive and relationship-intensive.

During labor, midwives employ a watchful waiting approach. Midwives protect, support and avoid interfering with normal physiologic processes. Midwives accept greater variations within the range of normal as long as there are no indications that mother or baby is in danger. The goals of midwives during the birth process are to support laboring women, be with the woman almost continuously, identify and treat complications with the least intervention-

93 Rooks, supra note 81, at 372.
94 Id. at 370.
95 Id.
96 Id. at 372.
97 Id.
98 Id. at 371.
99 Id. at 371-72.
100 Id. at 370.
101 Id. at 372.
102 Id.
103 Id. at 373.
104 Id.
al approach until the situation requires more, and allow the family to have a safe, emotionally healthy birth experience. Midwives are acutely aware that “pregnancy results in a mother as well as a baby.”

II. MIDWIFERY AND THE STATE

A. Legal Basis for States’ Power to Regulate Health Professions

Governments have regulated the practice of medicine since its advent in ancient times. Nevertheless, medical practice was largely unregulated in the United States until the nineteenth century. American allopathic physicians decided to professionalize during the middle of the 1800s, however, in response to ongoing concerns about the quality of traditional allopathic medical education and training and the widespread availability of practitioners trained in alternative schools of medical thought. In 1847, the American Medical Association was formed with a primary goal of establishing medical practice standards. These physicians lobbied state legislatures to enact professional medical licensing laws and to create and empower state boards of medicine to enforce licensing requirements that prevented the unlawful practice of medicine without a state license.

As more states enacted medical licensure laws, unlicensed practitioners began to challenge state’s legal authority to ratify such laws. However, the judicial challenges only affirmed the power of states to license medical professionals. In 1889, a man was unlawfully found to have violated a West Virginia statute for engaging in the practice of medicine without a license. The United States Supreme Court held

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105 Id.
106 Id.
107 See Grace J. Wigal, Issues in Physician Licensure, in The Physician’s Perspective on Medical Law, Volume II 293, 294 (Howard K. Kaufman & Jeff L. Lewin eds., 1997). Four thousand years ago, for example, Babylonians enacted provisions in the Code of Hammurabi to punish the negligent treatment of Babylonians and to establish fees for medical care. In Greece and Rome, restrictions on admissions to education regulated who could practice medicine. Id.
108 See id. at 295-96; see also Alyson Reed & Joyce E. Roberts, State Regulation of Midwives: Issues and Options, 45 J. Midwifery & Women’s Health 130, 130 (2000).
109 See Mosby’s Pocket Dictionary, supra note 64, at 49. Allopathic medicine is the dominant school of medical thought, and what is considered “modern medicine” in the United States. Id.
110 Wigal, supra note 107, at 296.
111 Id.
112 Reed & Roberts, supra note 108, at 130.
that a state's power to enact laws relating to the general welfare of its citizens authorizes the state to ratify regulations that will "secure . . . [citizens] against consequences of ignorance and incapacity, as well as deception and fraud." The Court asserted that this was especially true in the profession of medicine.

Although people commonly consult medical practitioners, the average person does not have the capabilities to evaluate whether the practitioner possesses the requisite qualifications. The idea that healthcare consumers need state protection from untrained and unscrupulous medical professionals reflects certain assumptions about patients. The first belief is that not all patients can evaluate the quality of medical providers or medical services. The second is that consumers place a great deal of trust in medical providers. Unless protected, unethical practitioners will defraud trusting consumers. Thus, state legislatures enacting medical licensure laws could cite patient safety, improvement of public confidence and protection of professional welfare as legitimate state goals.

In the early 1900s a state's power to enact laws related to public health and welfare became known as a state's "police power." In the seminal case Jacobson v. Massachusetts the United States Supreme Court laid the foundation for state regulation of health related laws. Jacobson explained that states have powers to enact "health laws of every description" that are reasonable to protect public health and public safety. Courts would only interfere with a state's decision where regulations were "arbitrary and oppressive."

By 1955, the Supreme Court announced that any state laws within a state's police power would not be scrutinized as long as the law conceivably is reasonably related to a legitimate government purpose. Justice Black expressed the same sentiment when he wrote: "[u]nder the system of government created by our Constitution, it is

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114 Id. at 122.
115 Id.
116 Id. at 122-23.
117 Wigal, supra note 107, at 293.
118 Id.
119 Id.
120 Id.
122 197 U.S. 11 (1905).
123 Id. at 25.
124 Id. at 38.
up to legislatures, not courts, to decide on the wisdom and utility of legislation."\(^{126}\)

B. State Statutory Regulation of Direct-Entry Midwives

Since states regulate direct-entry midwifery, there is widespread variation in laws from jurisdiction to jurisdiction.\(^{127}\) A statement that direct-entry midwifery is "permitted" or "prohibited" in a particular state is an overly simplistic representation of the midwife's actual legal status. Determining the legal status of a direct-entry midwife in any given state requires evaluation of statutory law, judicial interpretations and licensure requirements set by administrative regulatory boards of health, nursing, medicine and midwifery.\(^{128}\)

As of July 2009, twenty-six states licensed, certified, registered or permitted direct-entry midwives to practice within state boundaries.\(^{129}\) Nine more states allowed direct-entry midwives to practice based on judicial interpretation of a statutory reference.\(^{130}\) In four states the direct-entry midwife remains totally unregulated, and two states allow direct-entry midwifery with licensure, but the states do not offer licensing.\(^{131}\)

Even in the states that prohibit direct-entry midwifery, there is a significant variation in statutory law. The classic way states prohibit direct-entry midwifery is by restricting the practice of medicine to


\(^{127}\) Reed & Roberts, supra note 108, at 135.

\(^{128}\) Id.

\(^{129}\) See supra note 19 and accompanying text. Washington State is an excellent example of a state where progressive state policies have supported the development of direct-entry midwifery. Washington requires all practicing midwives to be licensed in the state. WASH. REV. CODE. § 18.50.005 (2010). Licensure requires that a direct-entry midwife: (1) receive a certificate or diploma from a state-accredited midwifery program; (2) obtain three years of basic midwifery training; and (3) undertake care of fifty women in the prenatal, intrapartum and postpartum periods and observe an additional fifty women in the intrapartum period. Id. at § 18.50.040. Licensed midwives are independent practitioners, required only to “consult with a physician when there are significant deviations from normal in either mother or the infant.” Id. at § 18.50.010. A midwifery advisory committee, consisting of a physician, CNM, three licensed midwives and a public member, advises and makes recommendations on issues involving midwifery. Id. at § 18.50.150. Washington’s flagship midwifery school has been educating midwives and advocating the expansion of midwifery for the last thirty years. See Department of Midwifery (formerly Seattle Midwifery School), BASTYR UNIVERSITY, http://www.seattlemidwifery.org/ (last visited Jan. 30, 2011). Finally, the state Medicaid program provides reimbursement for midwife attended births in the hospital, outpatient and home birth settings. Myers-Ciecko, supra note 63, at 388.

\(^{130}\) See supra note 19 and accompanying text.

\(^{131}\) See supra note 19 and accompanying text.
only approved persons. The state then excludes direct-entry midwives from the categories of licensed persons that can practice medicine. Midwives that practice without a license directly violate state law and may be prosecuted by state officials. Other states prohibit direct-entry midwifery by statutorily allowing only midwives possessing a license from the state health department to practice. The health departments then refuse to issue licenses to direct-entry midwives, so there is no real way to become a legally licensed direct-entry midwife.

C. Midwives’ Health Outcomes and State Abuse of Licensing Powers

Throughout this Note it is recognized that states are legitimately exercising their police power to protect the public’s health and safety when they regulate or license direct-entry midwives. States can achieve the goal of protecting the public’s health from unskilled or fraudulent practitioners by providing for the licensure of direct-entry midwives.

132 South Dakota provides an example of a state whose laws exclude midwives from the category of persons who may practice medicine. South Dakota specifies that people shall not diagnose or treat “human ill[s]” unless the person is licensed to practice the “healing art[s].” S.D. CODIFIED LAWS § 36-2-2 (West 2010). An exemption is provided for nurse midwives but not for direct-entry midwives. See id. at §§ 36-9A-1 & 36-9A-4 (West 2010). Kentucky, Maryland, Indiana, Illinois, and Iowa all prohibit direct-entry midwives in the same statutory manner. Kentucky Revised Statutes § 311.560 prohibits the practice of medicine or osteopathy without a license but § 314.011 and § 314.042 license advanced register nurse practitioners to practice, and this category includes nurse-midwives. KY. REV. STAT. ANN. §§ 311.560, 314.011–042 (West 2010). Maryland follows the similar pattern, but has special rules that govern nurse midwives to specify regulations that apply only to the practice of nurse midwifery. See MD. CODE. ANN., Health Occupations §§ 8-602, 14-101 (LexisNexis 2008).

133 Alabama takes this approach to prohibiting direct-entry midwifery. In the portion of Alabama Code that pertains to nursing, Section 34-19-3 (b) provides that “nothing . . . shall prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery . . . . ALA. CODE § 34-19-3(b) (LexisNexis 2007). Although Alabama’s Code does permit lay midwifery by those with health department licenses, Alabama’s county health departments stopped issuing licenses in the mid 1970s. History of Legislative Effort in Alabama, ALABAMA MIDWIVES ALLIANCE, http://www.alabamamidwivesalliance.org/aboutalma.html (last visited Nov. 12, 2010). This roundabout prohibition of midwives was challenged in 1995 by Toni Kimpel, a direct-entry midwife, after she was charged with practicing nurse midwifery without a license. See State v Kimpel, 665 So.2d 990, 991-94 (Ala. Crim. App. 1995). During the case, the court determined that Kimpel did not possess a license and the court further stated, “in fact, no one possesses a valid health department permit for the practice of lay midwifery. This provision was grandfathered in the 1975 government objective.” Id. at 994 n.3.
But when states refuse to legally recognize the direct-entry midwife, states exceed the limits of their police power and abuse their licensing privileges. This section will show that this legal prohibition is not justified by the medical outcomes of direct-entry midwives. Scientific, social and economic research demonstrates the numerous benefits midwives provide to society. Licensing and regulating midwives achieves state health and safety goals better than a prohibition on the practice of midwifery.

1. Education and Qualification of Direct-Entry Midwives

Since the 1990s, professional midwifery associations have focused on standardizing the education and certification process for direct-entry midwives. Both the Midwives Alliance of North America (MANA) and the American College of Nurse-Midwives (ACNM) provide processes for education and certification of direct-entry midwives.

MANA’s certifying body, the North American Registry of Midwives (NARM) does not require that midwives complete a formal university education, but instead has general education and apprentice-training requirements. In order to be recognized as a Certified Professional Midwife by NARM, a midwife must: (1) meet all education requirements and pass a certification exam; (2) meet minimum experience requirements that include a certain number of prenatal exams, infant deliveries, newborn exams and postnatal exams; and (3) document proficiency in all midwifery skills. Alternatively, direct-entry midwives may be certified after attending an accredited formal midwifery program. All Certified Professional Midwives must adhere to practice guidelines and have written emergency care plans if medical backup becomes necessary during practice.

NARM estimates that the average clinical and doctrinal training of a Certified Professional Midwife lasts between three to five years. The variance in the length of midwifery education is likely due to the experience requirements and the volume of available pregnant women at a given time. CPM candidates must attend forty births

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134 Reed & Roberts, supra note 108, at 134.
135 Id.
136 Id.
137 Id.
139 Id.
140 Id.
and conduct seventy-five prenatal exams, twenty newborn exams and forty postpartum exams, all under the direct supervision of a clinical instructor.\footnote{141}

Midwifery education does not end with certification. Every three years a CPM must renew certification.\footnote{142} NARM seeks to uphold professional accountability through continuing education requirements, updating practice guidelines and maintaining a peer review process.\footnote{143} NARM has a formal complaint process and can revoke CPM status if necessary.\footnote{144}

Unlike NARM, the ACNM certification requires that all midwifery candidates hold a baccalaureate degree and affiliate with an institution of higher midwifery education.\footnote{145} Thus, the ACNM certification process for the direct-entry midwife mirrors that of the certified nurse-midwife. Both the non-nurse and nurse midwives must have the same competencies and meet the same educational standards to achieve certification.\footnote{146} Most states use NARM certification to license or certify direct-entry midwives, but states may also impose alternative or additional educational requirements.\footnote{147}

Because educational requirements for midwives vary greatly, researchers sought to compare and evaluate the education obtained by nurse midwifery students and direct-entry midwifery students in the same program at the State University of New York Health Science Center.\footnote{148} The researchers anticipated that the non-nurse direct-entry students would be disadvantaged, because they did not have prior nursing education, as compared to nurses in a standardized midwifery education program.\footnote{149}

\footnote{141} Id.
\footnote{143} Id.
\footnote{144} Id.
\footnote{145} Reed & Roberts, \textit{supra} note 108, at 134.
\footnote{146} Id.
\footnote{147} See id. at 138-40. Reed and Roberts note that there are wide variations in individual state requirements but provide some state specific examples. Midwives in Washington State, Rhode Island and New York are required to complete a state accredited educational program at an official school of midwifery. Id. at 139. Alaska requires that midwives complete an “acceptable organized course of study on subjects related to health and social sciences.” Id. In Texas, midwives’ basic education program must include at least 250 hours of course work. Id. New Hampshire requires midwives to take college-level anatomy and physiology courses. Id. at 140. Similarly, Louisiana also requires the college courses, but adds psychology, nutrition and pregnancy and childbirth to the list of courses. Id. at 139. Arizona lists college level core subjects that midwives must take but also specifies that midwives must obtain scores of 80 percent or better in the courses. Id.
\footnote{148} Judith T. Fullerton et al., \textit{Direct Entry Midwifery Education: Evaluation of Program Innovations}, 43 J. NURSE-MIDWIFERY 102, 102.
program. The study determined that there was no difference in academic performance between the two categories of students. In the clinical setting, where nurses should certainly have an advantage because of their prior training, both direct-entry and nursing students similarly demonstrated and obtained obstetric skills.

Overall, although there is variation in direct-entry midwifery training across states and professional associations, direct-entry midwives are highly educated, clinically competent and well-prepared to care for the low-risk mother and baby.

2. Health Outcomes of Direct-Entry Midwives

States frequently cite the protection of the public from incompetent practitioners who provide poor healthcare as the primary reason for prohibiting practice by alternative healthcare providers, including direct-entry midwives. However, factual evidence demonstrates that direct-entry midwives consistently provide high-quality, family-centered care to mothers and infants. Thus, states that continue to prohibit direct-entry midwifery are acting based on unsubstantiated notions of unsafe midwifery practice. Because medical outcomes support the safety of direct-entry midwifery, states’ goals of promoting public health and welfare can best be achieved by licensing and expanding the practice of midwifery rather than by restricting it.

Since many midwives practice in the home birth setting, researchers conducted a large prospective study of North American certified professional midwives’ practice and compared midwives’ outcomes with those of obstetricians practicing in the hospital setting. The study found that women laboring at home under the supervision of a midwife had similar intrapartum and neonatal mortality to that of low-risk births in hospital settings. No women died at home giving birth, and infant mortality was two out of one thou-

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149 Id.
150 Id. at 105.
151 Id.
154 Id. at 1417.
155 Id.
sand during the home births. This rate is consistent with infant mortality rates in hospitals.

The study also reported a high degree of safety and maternal satisfaction with midwife-attended births. This indicates that midwife-attended low-risk births are as safe as physician-attended low-risk births. Furthermore, many women enjoy the home birth experience and trust midwives more so than physicians.

The study found that of the 5,418 women in the study, roughly 12% were transferred to the hospital during the intrapartum period, most frequently for failure to progress with the delivery, pain relief or exhaustion. This data constitutes evidence that midwives do transfer their patients to the hospital in appropriate situations.

Finally, the study also found that rates of medical intervention by midwives in the home birth setting were less than half of those in the hospital. This indicates that midwife-attended low-risk births may ultimately prove to be safer and less costly than physician-attended low-risk birth. Infrequent use of interventions by midwives is not associated with increased risk to mother or baby, and experts are now using the low intervention rates as benchmark rates that should be achieved in all childbearing women. The study comparing midwife-attended home birth and hospital birth is one of the largest ever conducted in North America, but the results are consistent with other current and historical studies of the practice of midwifery.

156 Id.
157 Id.
158 Id. at 1417-19.
159 Id. at 1417.
160 Id. Interventions included electronic fetal monitoring, intravenous medication administration, artificial rupture of membranes, epidurals, induction of labor, stimulation of labor, episiotomy, forceps use, vacuum extraction and caesarean section. “[H]ome births were associated with lower rates of electronic fetal monitoring (9.6% versus 84.3% in the hospital), episiotomy (2.1% versus 33%), caesarean section (3.7% versus 19%) and vacuum extraction (0.6% versus 5.5%)”. Id.
161 SAKALA & CORRY, supra note 91, at 29; see generally Johnson & Daviss, supra note 153.
The connection between low obstetrical intervention rates in a low-risk birth and positive health outcomes for mother and baby cannot be emphasized enough. Current research repeatedly shows that physicians in hospital settings use obstetric interventions during low-risk births at alarmingly high rates. Obstetric interventions that were originally developed for specific problems in the high-risk pregnant population are now liberally and routinely used in normal, low-risk births. Physician and institutional convenience, the incentives of a fee-for-service payment system, the adverse effects of the malpractice system, limited reliance on best-evidence maternity guidelines, and reliance on obstetric specialists to provide care in the normal pregnancy are all frequently cited as the reasons for high intervention rates in low-risk births in hospital settings.

High intervention rates are problematic because when interventions are performed, mothers and babies potentially become susceptible to additional adverse complications. The overuse of interventions in the low-risk population "exposes many mothers and babies to risk of harm with marginal medical benefit or none at all." Interventions are applied liberally in the low-risk population often without consideration of less invasive alternatives, and the interventions require co-

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163 See Rooks, supra note 24, at 28; The White House Conference on Child Health and Protection, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1556301/. The White House Conference on Child Health and Protection issued a report stating that maternal mortality had not declined between 1915 and 1930, despite the increase in physician-attended hospital delivery, the introduction of prenatal care, and the use of aseptic techniques. The number of infant deaths from birth injuries increased by 40 to 50% from 1915 to 1929, possibly because excessive intervention occurred in the hospital and was often improperly performed by the physician.

164 See generally Sakala & Corry, supra note 91 (finding that “[m]any maternity practices that were originally developed to address specific problems have come to be used liberally and even routinely in healthy women.”); Johnson & Davis, supra note 153 (evaluating the safety of home births compared to low risk hospital births); Rosenblatt et al., supra note 3 (noting that one factor that predisposes a woman to cesarean section is the individual providers’ practice style); Kathleen R. Simpson & Kathleen E. Thorman, Obstetric “Conveniences,” Elective Induction of Labor, Cesarean Birth on Demand, and Other Potentially Unnecessary Interventions, 19 J. Perinatal & Neonatal Nursing 134 (2005) (finding that “[o]bstetric procedures and interventions performed solely for convenience often have the opposite of the intended effect.”); Wagner, supra note 1 (noting that in countries where midwives are the primary care takers in the maternity care system, 70% of women never see a doctor for a birth related complications).

165 See Simpson & Thorman, supra note 164, at 134-41.

166 Id. at 134.

167 See Sakala & Corry, supra note 91, at 5.

168 Id. at 35.
interventions to monitor, treat and prevent side effects. Further, interventions are associated with elevated pregnancy costs.  

Cesarean sections are one intervention that is currently under intense scrutiny from pregnant women, birth advocates, the media, health officials, insurers and policymakers. The national cesarean rate has been climbing since the mid-1990s and it is now estimated that one in three women give birth by cesarean section. Cesarean sections are life-saving procedures for mothers and babies in certain circumstances. But many mothers considered unlikely to need cesarean sections are undergoing the procedure in the United States. Experts are worried that American hospitals are doing too many unnecessary cesarean sections and heightening the risks to mother and child. Researchers conclude that national cesarean rates between 5%–10% are optimal and normal, but cesarean rates above 15% cause more harm than good.

Health officials and researchers are trying to explain why so many pregnancies unlikely to need surgical intervention are resulting in cesareans. Physicians admit that determining when a woman needs a cesarean section is an imperfect discipline that is influenced by fear of malpractice suits. One physician acknowledged that the cesarean rate “is probably higher than it should be, and it reflects the defensive

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169 This phenomenon where co-interventions must be used to monitor, treat or prevent side effects from the original single intervention is known as the “cascade of intervention.” See infra note 225 for full explanation. An example of this is when synthetic hormones are used to induce a low-risk pregnant woman’s labor. The woman requires an intravenous line to deliver the hormones. The synthetic hormone causes her contractions to become stronger and more frequent than normal labor contractions. This increase in maternal pain frequently results in the need for epidural analgesia. An epidural requires a woman to have a bladder catheter, remain in bed, be given intravenous fluids and have a continuous fetal monitor on. The woman cannot adequately feel contractions during the pushing stage of labor, so she must be told when to push. The hormones and epidural can prolong the second stage of labor, ultimately resulting in a cesarean section.

170 SAKALA & CORRY, supra note 91, at 35.

171 Id. at 41.

172 The circumstances when cesarean section is necessary are: prolapsed umbilical cord (where the cord precedes the infant’s head through the birth canal), placenta previa (where the placenta has grown over the cervical opening), placental abruption (where the placenta has prematurely separated from the uterine wall prior to the birth of the infant), and persistent transverse lie (where the fetus is positioned horizontally and does not move into a vertical position prior to labor). SAKALA & CORRY, supra note 91, at 41.


174 Id.

175 SAKALA & CORRY, supra note 91, at 42.

176 Spector, supra note 173.
practice of obstetrics." But fear of malpractice suits is not the only reason physicians surgically intervene.

There is widespread disagreement about the conditions that indicate cesarean section. Midwives and physicians agree that prolapsed umbilical cord, placenta previa, placental abruption and persistent transverse lie are absolute indications for cesarean section. More controversial is the use of cesarean section in breech fetal presentation, failure to progress during labor, delivery of twins, repeated cesarean section and elective cesarean sections. Because midwives are trained differently from obstetricians, midwives are more likely to opt for watchful monitoring, extend time frames during labor, perform external versions of breech fetuses, vaginally deliver twins, and vaginally deliver infants after the mother has had a previous cesarean section. Unlike midwives, many physicians trained in the medical model find surgical techniques and interventions easier for them to master and faster to carry out.

Further complicating the situation is the need for resident obstetricians in training to perform a certain number of interventions prior to graduation from residency. The mandatory quotas encourage residents to intervene during birth. As a result, resident obstetricians become excellent at managing emergency high-risk situations. But the obstetricians miss the hands-on diagnostic, watchful waiting and minimal intervention training that makes midwives excellent practitioners for the low-risk population.

Overall, state legislatures that prohibit direct-entry midwifery should recognize that throughout American history midwives have consistently proven that they are safe practitioners for normal pregnancies. Further, because midwives are trained in the midwifery model of care, they use interventions in the low-risk population at much lower rates than obstetricians. This ultimately benefits low-risk mothers and babies.

3. Midwives As Primary Providers in Low-Risk Populations

Most states in the United States have recognized the value of midwifery. Washington and Florida are progressive leaders in the midwifery renaissance. Washington recognizes different types of
midwives, provides licensing mechanisms, articulates clear standards that conform to the midwifery model, has leading midwifery schools and reimburses for midwifery expenses. Similarly, Florida established a state goal of having midwives provide intrapartum care to one half of all pregnant mothers in the state and celebrates the contributions midwives have made to the health of mothers and babies during National Licensed Midwives Week.

Outside of the United States, midwife-attended births are the norm. One birth expert notes "[e]very single country in the European Region with perinatal and infant mortality rates lower than the United States uses midwives as the principal and only birth attendant for at least 70% of all births . . ." In most European countries, midwives are the central caregivers for low-risk women and these pregnant women never see a physician unless they develop complications. Notably, no European country that relies on midwives as central caregivers in normal pregnancies and birth has a caesarean section rate over 15%, and these countries boast lower infant mortality rates than the United States.

These striking European statistics imply that not only are midwives as safe as obstetricians in the low-risk population, but midwifery is necessary for the improvement of infant mortality in the United States. The use of midwives as central caregivers in low-risk women and obstetric physicians in high-risk cases has been a successful model in Europe. Similarly, the expanded use of midwives in the United States could help reduce delivery-associated intervention rates and increase access to pregnancy care.

Recently, the National Center for Health Statistics released a Data Brief on maternal and infant mortality in the United States. The

183 See Myers-Ciecko, supra note 63, at 387-89.
186 Wagner, supra note 1, at 443.
187 Wagner, supra note 1, at 443-44.
188 Wagner, supra note 185, at 481 (observing that in European countries where midwifery is the primary maternity care, the perinatal and infant mortality rates are lower than the United States).
189 Wagner, supra note 1, at 443-44.
report concluded that the United States' infant mortality rate is higher than that in most other industrialized countries, and the gap between the United States and the countries with the lowest infant mortality rate is widening.\textsuperscript{191} Despite having the most technologically advanced birth practices, the United States only tied with Poland and Slovakia for the twenty-ninth spot on the international ranking of infant mortality.\textsuperscript{192} Further, infant mortality statistics indicate that in the United States there are large disparities in infant mortality based on race and ethnicity.\textsuperscript{193} The Non-Hispanic Black population had the highest mortality rates.\textsuperscript{194}

While the United States' infant mortality rate is startlingly high for an industrialized nation, experts are confident that it can be improved. One way to improve the infant mortality rate is by expanding midwifery and utilizing midwives as they are used in Europe.\textsuperscript{195} In all European countries midwives provide most of the prenatal, intrapartum and postnatal care in uncomplicated births.\textsuperscript{196} The division of labor "is fundamental to the entire perinatal care system in the European Region" because midwives and physicians approach pregnancy and birthing from different perspectives, but "two styles nicely complement each other."\textsuperscript{197} Obstetricians are available when emergency situations necessitate medical interventions and a strong independent midwifery profession counterbalances excessive interventions by obstetricians during the normal birth process.\textsuperscript{198}

It is in this cooperative approach to pregnancy and birthing that the United States fails. Consequently, the United States has one of the highest obstetrical intervention rates of any nation.\textsuperscript{199} This is problematic because lower obstetrical interventions are generally associated with lower infant mortality rates.\textsuperscript{200} What the European experience and clinical data strongly support as a solution to the United States' high rates of infant mortality is "the introduction of widespread, inde-

\begin{itemize}
  \item \textsuperscript{191} Id. at 1.
  \item \textsuperscript{192} Id. at 2.
  \item \textsuperscript{193} Id. at 3.
  \item \textsuperscript{194} Id.
  \item \textsuperscript{195} See Wagner, supra note 185, at 480.
  \item \textsuperscript{196} Id.
  \item \textsuperscript{197} Id.
  \item \textsuperscript{198} Id. at 480-81.
  \item \textsuperscript{199} Id. at 481. Wagner describes interventions as "when the baby is either pulled out by forceps or vacuum extractor, or lifted out through a surgical cut in caesarean section." Id. at 478.
  \item \textsuperscript{200} See id. at 478-81 (noting that particularly for caesarean section, the financial and human cost in the United States is "staggering," and that woman and baby are paying a considerable "human price" for the excessive use of this obstetrical intervention).
\end{itemize}
dependent midwifery practice . . . 

The American Public Health Association has also endorsed the expansion of midwifery in the United States.

Ultimately, health outcome data indicates that by prohibiting direct-entry midwives from practicing, legislatures are jeopardizing the health and well-being of women and infants. Legislatures are not accomplishing the goals of “promoting public health” and “protecting mother and fetus from incompetent providers” through overly restrictive statutory midwifery prohibitions. Research and clinical data indicates that restricting access to direct-entry midwives, instead of licensing and regulating competent providers, is counterproductive.

4. Impact on Health Disparities and Cost

The United States’ federal and state government initiatives to lower the infant mortality rates have concentrated on reducing financial barriers that limit access to prenatal care and on expanding prenatal care services to poor and underserved pregnant women. States that refuse to license and regulate direct-entry midwives disrupt this goal.

Historically, midwives have provided care to the nation’s poorest women and children.

So, the burden of restricting access to midwifery care is felt not only by women actively seeking access to midwives for an alternative birth experience, but also by the poorest, most vulnerable women in the population. Physicians typically under-serve poor women in both urban and rural regions. Reasons for the disparity between the financially stable and the poor include lack of practicing obstetricians, low Medicaid payments, and unwillingness of the obstetrician to ac-

201 Id. at 481.
205 See Mottl-Santiago, supra note 22 at 234.
cept uneducated, immature, unmarried pregnant women who typically have poor health habits.\textsuperscript{206} In some urban cities research determined that 70–80\% of all practicing obstetricians refuse to accept Medicaid clients.\textsuperscript{207}

There are over 4.3 million births each year in the United States.\textsuperscript{208} Nurse-midwives help reduce public health burdens by caring for the poor, but there are simply not enough nurse-midwives to fill the void.\textsuperscript{209} Yet poor and rural women are the people most in need of pregnancy care.

The poorest prenatal health services are found in low-income African-American, Latino, immigrant and transient communities.\textsuperscript{210} In the Health of America report the CDC indicates that more poor women tend to get only third trimester care or no prenatal care and consequently have the highest infant mortality rates.\textsuperscript{211} In situations where minority women do receive maternity care, researchers are raising concerns about the quality of care the women receive and suggest that lower quality care may contribute to poorer health outcomes.\textsuperscript{212} By restricting access to direct-entry midwives, state legislatures impose the heaviest burden on poor minority women.

If given the opportunity, midwives could play an important role in improving access to care for all women, regardless of socioeconomic status. The midwifery model of care directly aligns with the goals and aims of public health programs that advocate for empowerment of women's health.\textsuperscript{213} Midwives are in a unique position to provide woman-centered care that "emphasizes health education and supportive techniques designed to help women make healthy decisions . . ."\textsuperscript{214} Since midwives approach women's health from a holistic perspective, they are well-equipped to comprehensively address

\begin{thebibliography}{19}
\bibitem{206} Rooks, \textit{supra} note 24, at 104.
\bibitem{207} Wagner, \textit{supra} note 1, at 444.
\bibitem{208} SAKALA \& CORRY, \textit{supra} note 91, at 10.
\bibitem{209} Nurse midwives deliver only 8\% of the babies born each year in the United States and most of them practice in the hospital setting. \textit{Differences Between Nurse-Midwives, Other Midwives and Doulas}, AM. COLL. OF NURSE-MIDWIVES, http://www.mymidwife.org/nurse_midwife.cfm (last visited Nov. 12, 2010).
\bibitem{210} INTERNATIONAL REPRODUCTIVE RIGHTS RESEARCH ACTION GROUP, \textit{NEGOTIATING REPRODUCTIVE RIGHTS: WOMEN'S PERSPECTIVES ACROSS COUNTRIES AND CULTURES} 268 (Rosalind Petchesky \& Karen Judd eds., 1998).
\bibitem{212} See SAKALA \& CORRY, \textit{supra} note 91, at 17.
\bibitem{213} Mottl-Santiago, \textit{supra} note 22, at 235.
\bibitem{214} \textit{Id}.
\end{thebibliography}
the diverse problems that poor women face in achieving good health outcomes for themselves and their babies.

Another advantage of expanding midwifery to states that currently prohibit direct-entry midwives is a reduction in healthcare costs. Each year, childbirth is the leading reason for hospitalization in the United States. In 2005, the United States spent over $79 billion dollars on hospital charges for birthing women and newborns. Private insurers and Medicaid have made more payments for childbirth than for all other disease conditions combined.

The average cost for a twenty-four hour hospital stay following an uncomplicated delivery is between $8,000 and $10,000 with the rate doubling for cesarean sections. The average cost of childbirth in a freestanding birth center is $1,600. Researchers note that much of the difference in cost between a hospital birth and a birth center delivery is related to the procedure-intensity of hospitals. Obstetric procedures account for nearly half of all hospital procedures performed on individuals aged fourteen to forty-four and cesarean sections are one of the most common operations.

Midwives, who primarily practice in the low-cost home birth or birthing center settings, are a high quality solution to the rising cost of childbirth. For example, home births can offer a savings of 68 percent for childbirth while also offering safety, low rates of neonatal mortality and decreased numbers of cesarean births. Expanding the use of midwife-attended births in the home birth and birthing center settings can drastically reduce maternity costs, but increasing the use of midwives in the hospital setting is also a solution to escalating hospital costs.

Licensing and credentialing more midwives to practice in hospitals will also help reduce the procedure-intensity of hospital obstetrics, thereby decreasing overall hospital costs. A study that compared physician and midwife childbirth charges found a significant difference

215 SAKALA & CORRY, supra note 91, at 10.
216 Id. at 10-11.
217 Id. at 11.
219 SAKALA & CORRY, supra note 91, at 12.
220 Id. at 11.
221 Id. at 11-12.
between fees charged by obstetricians and nurse-midwives. 223 Midwives' lower hospital-based charges are related to reduced level of interventions during birth. 224 Because midwives are less likely to intervene during pregnancy, the "cascade of intervention" does not become "a cascade of costs as one intervention leads to another." 225

Maternity care currently plays a substantial role in escalating health care costs. 226 The financial stabilities of families, employers and federal and state budgets are at stake. 227 States facing soaring Medicaid and health care costs can contain some of the cost for childbirth simply by licensing direct-entry midwives and advocating for their increased use in the hospital, community, and home birth settings. Women will receive low-cost but high-quality care, and states will have curtailed childbirth expenditures.

5. State Protection of Birth as a Physician Enterprise

The value of midwifery is enormous. Expanding direct-entry practice to all states is logical when one considers health outcomes and cost. Yet, one question looms. Why are legislatures who are presented with positive birthing outcomes, potential solutions to reduce infant mortality rates, increased prenatal care in the poorest populations and health care cost reductions still hesitant to expand licensure to direct-entry midwives? Most scholars answer that legislatures are expressing a preference for physician-direct childbirth to protect the obstetric profession. 228

223 Catherine A. Carr, Charges for Maternity Services: Associations with Provider Type and Payer Source in a University Teaching Hospital, 45 J. MIDWIFERY & WOMEN'S HEALTH 378, 381 (2000).
224 Id. at 382.
225 Id. The "cascade of intervention" is frequently used to describe when a single intervention during pregnancy leads to the need for many more. The article provides the following example: women who are connected to intravenous lines are less likely to ambulate due to physical restriction, so the women are restricted to bed, which makes continuous fetal monitoring more likely and leads to an increased need for analgesia for pain relief. Id. See also Hafner-Eaton & Pearce, supra note 2, at 817 (describing the "cascade of intervention" as the "negative effects of one human intervention or labor management technique" that requires "yet another intervention to correct the first."). The example that is given is when a woman's membranes are artificially ruptured, the loss of fluid may result in a prolapsed cord, intruterine infection from exposure to germs, or both. Id.
226 SAKALA & CORRY, supra note 91, at 12.
227 Id.
228 See ROTHMAN, supra note 23, at 172 (calling the physician control of obstetrics a "medical monopoly"); Tew, supra note 179,12-26; Hafner-Eaton & Pearce, supra note 2, at 814 (stating that many legal and social sanctions work against parents' desire for home birth and the use of nonmedically trained birth practitioners); Suarez, supra note 62, at 320 (arguing that "[e]conomics is the hidden agenda" in
During the physician-led campaign to eliminate midwifery in the 1900s Charles Ziegler uttered what was to become an infamous statement, reflective of the constant battle between physicians and midwives. Ziegler said:

My own feeling is that the great danger lies in the possibility of attempting to educate the midwife and in licensing her to practice midwifery, giving her thereby a legal status which later cannot perhaps be altered. If she once becomes a fixed element in our social and economic system . . . we may never be able to get rid of her.\(^\text{229}\)

The campaign to limit midwifery continues by modern physicians. At its November 2005 Interim Meeting, the American Medical Association (AMA) House of Delegates adopted Resolution 902 titled, "Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners." The resolution reflected Charles Ziegler’s sentiments when it stated:

RESOLVED, That our AMA, through the Scope of Practice Partnership, immediately embark on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising their full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by boards of nursing or other entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice. (Directive to Take Action).\(^\text{230}\)

Physicians and legislatures using state powers to protect birth as a physician enterprise are further aided by the legal structure of state licensing procedures. State statutes control licensure of health care

\[^{229}\text{Charles Edward Ziegler, The Elimination of the Midwife, 60 JAMA 32, 32-38 (1913).}\]
professionals, and prohibit unlicensed professionals from providing services reserved for the licensed health care professionals. The state statutes are implemented by licensure boards, which operate as state agencies.\footnote{231} Members of the licensed profession, however, generally dominate the state licensure boards.\footnote{232} This effectively creates a “system of professional self-regulation, even though the boards act as state agencies . . .\footnote{233}” This professional domination of licensure is strongly criticized as “serving the interests of the professions at the expense of their competitors and of the public.”\footnote{234}

Because state licensure is structured in this manner, physicians effectively sit on and control the state licensure boards. People who seek to change state laws to include direct-entry midwives in the category of licensed professionals must lobby and convince legislatures, who are advised by the physician-dominated licensure boards, to change the controlling statutes.

Physician influence on legislatures surely impacts the prohibition of midwifery, but physicians’ desire for a monopoly on childbirth is likely just one of multiple factors.\footnote{235} Also contributing to the skewed view of midwifery in the United States are hospital interests, the legal structure of America and the mass media.\footnote{236}

Physicians and hospitals have a financial incentive to keep birthing women in the hospital.\footnote{237} With the fee-for-service payment structure, physicians and hospitals are also encouraged to perform more interventions and fill facility beds.\footnote{238} Because physicians and hospitals receive higher payments for more intense interventions, even though the interventions lead to longer hospital stays, a perverse incentive is created for physicians to perform more interventions.

Further, hospitals and physicians can control the media because they have influence over professional medical journals, publishers, professional societies and state boards of health.\footnote{239} Thus, limited views promoting obstetrics can be presented in the popular media.\footnote{240} Midwifery advocates note that since the tradition of midwifery has been lost in the United States, major media promotion of the profes-
tion is essential. A Many Americans believe that midwifery is "second-class obstetrics" and this serious misunderstanding needs to be resolved.

Legislatures in the states that continue to prohibit direct-entry midwifery must move past political pressure from interest groups. After evaluating the empirical data without considering the agendas of the physicians and hospitals, lawmakers will certainly recognize that physicians, midwives and hospitals can all coexist to achieve better health for women and infants.

III. MIDWIFERY AND WOMEN'S RIGHTS

Lawmakers' decisions to prohibit direct-entry midwifery directly affects society. The public could substantially benefit from a movement toward a dual system of maternity care where licensed midwives provided care in low-risk populations and specialist obstetricians care for high-risk women. But behind the broad scale analysis of maternity care in the United States are still individual pregnant women. The discussion of midwifery is not complete without evaluating what rights women and their families have during pregnancy and what constraints they face from competing state interests.

A. Constitutional Limitations: Reproductive Rights After Roe v. Wade

During the 1960s the Supreme Court took monumental steps towards greater reproductive rights for women by establishing a right to privacy. In declaring unconstitutional a state law prohibiting the use and distribution of contraception, the Court recognized a constitutional right to privacy that limited the government's ability to intrude into the intimate matters of people's lives. In 1972, the Supreme Court expressly acknowledged not just a right to privacy but also a right to reproductive autonomy.

The following year, the Supreme Court decided the landmark case Roe v. Wade. The Court held that a woman has the right to terminate her pregnancy. The Court divided pregnancy into three trimesters. In the first trimester, the state could not prohibit abortions but could

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241 Wagner, supra note 1, at 445.
242 Id.
244 Id. at 485-86.
245 See Eisenstadt v. Baird, 405 US 438, 453 (1972) (Justice Brennan stated "If the right of privacy means anything, it is the right of the individual . . . to be free from unwanted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.").
LEGALIZING DIRECT-ENTRY MIDWIFERY

regulate them as medical procedures.247 During the second trimester, the state again could not prohibit abortions, but may regulate the medical procedure in ways reasonably related to maternal health.248 Finally, in the third trimester, abortions could be prohibited, except as necessary to preserve the health of the mother.249

This trimester scheme introduced the notion of viability.250 The Court recognized that states have an interest in preserving prenatal life, but that interest must be balanced against women’s competing privacy interest.251 The Court said it would not determine the difficult question of when life begins, but stated, “[W]ith respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability.”252 Viability is the point at which a fetus is “capable of developing, growing or otherwise sustaining life” outside of the mother’s womb.253

With the idea of viability in the national spotlight, a campaign for fetal rights commenced. Pro-life advocates argued that a viable fetus should have legal rights because of the high probability that the fetus will ultimately gain legal capacity through birth.254 Pro-lifers thought fetuses needed legal recognition and protection because the interests of mother and fetus can diverge.255 Thus, even though Roe delegated reproductive decision-making authority to women and physicians, pro-life activists gained support for fetal rights by disseminating the idea of the maternal-fetal conflict.256

Suddenly, a pregnant mother was pitted against her fetus. Woman and fetus were seen as conceptually separate, with each having rights and interests that could not coexist.257 After Roe, the perception of an independent fetus was associated with the legal classification of fetuses and fetal rights.

247 Id. at 164.
248 Id.
249 Id. at 164-65.
250 Id. at 163-65.
251 Id. at 164-65.
252 Id. at 163.
253 MOSBY’S POCKET DICTIONARY, supra note 64, at 1263.
255 See id. at 739.
In 1992 the Supreme Court officially abandoned the trimester scheme of Roe and moved to a pure viability scheme.\(^{258}\) The Court held in Planned Parenthood v. Casey that viability was the dividing line during pregnancy.\(^{259}\) Before viability, the government could not interfere with abortions.\(^{260}\) After viability, the government could prohibit abortions except where a mother’s life is in jeopardy.\(^{261}\) The Court declared that it was overruling Roe’s trimester framework because it “misconceives the nature of the pregnant woman’s interest and undervalues the State’s interest in potential life.”\(^{262}\)

While Roe and Casey were substantial victories for supporters of women’s reproductive rights, the decisions’ notions of viability provided ammunition for states and courts to limit a woman’s rights during the course of pregnancy. This is the double-edged sword of the reproductive rights cases. Casey provides autonomous women who exercise a right to privacy access to abortions before fetal viability. But after viability, women were seen as fetal containers that housed a fetus with independent rights and interests.\(^{263}\) Thus, after viability, states may adopt laws relating to pregnancy. This includes adopting restrictive licensing standards that exclude direct-entry midwives from attending births. Although these prohibitions subvert a pregnant woman’s birthing choices, Casey holds that the interest of the state in preserving fetal rights supersedes the mother’s privacy rights at viability.

The balance that Roe and Casey created between women’s privacy rights and state interests that are defined by viability is problematic, however, for issues beyond abortion. If it is accepted that a state may supersede individuals’ privacy rights at viability, is there a limit to how far the state may go? Can a state mandate that all women have medical births, in academic hospitals, by board certified physicians? May the state require biomedical interventions at delivery, even mandated cesarean sections? Are states overestimating the rate at which women and fetal interests are actually conflicting? Ultimately, does the state really have a compelling enough interest to pre-empt parental choices?

\(^{259}\) Id.
\(^{260}\) Id. at 872.
\(^{261}\) Id.
\(^{262}\) Id. at 873.
\(^{263}\) See Purdy, supra note 257, at 88.
B. State Judicial Decisions: Due Process Challenges to Midwifery Prohibitions

A limited judicial extension of the privacy right would seem to cover birthing options, including the choice of the direct-entry midwife as the birth attendant. Courts could create an exception to the viability scheme that recognizes parents’ choices of birth location, attendant and birth process. Historically, however, state supreme courts have rejected direct-entry midwifery prohibition challenges that were based on a woman’s right to privacy.

Such a privacy challenge was asserted in the 1976 California case *Bowland v. Santa Cruz*. Women challenged a statute that prohibited unlicensed midwives from practicing by arguing that the right to privacy encompasses the choice of birth attendant. The California Supreme Court determined that the privacy right was not broad enough to protect the choice of the “manner and circumstances” in which a baby is born. The court cited *Roe v. Wade* for support in excluding the right to choose a midwife from the right of privacy. Specifically, the court referenced *Roe’s* trimester scheme by stating that, at the point of fetal viability, the state’s interest in the life of the fetus supersedes a mother’s privacy rights. The court reasoned that state legislatures may prohibit unlicensed midwifery for the same policy reasons that states may prohibit abortions after the point of viability.

After the *Bowland* decision, the California legislature amended its licensing laws to include a licensing mechanism for direct-entry midwives. Nevertheless, the *Bowland* court’s holding and reasoning resonated in the judicial decisions of other states. Although some other states have followed *Bowland’s* precedent, the constitutional issue remains unsettled because the United States Supreme Court has never considered and resolved the issue of privacy in pregnancy.

In 1985, Janet Leigh challenged the suspension of her nursing license by the Massachusetts nursing board. Leigh’s license was suspended for her unauthorized practice of midwifery in violation of a nursing statute. In arguing her position, Leigh brought a due
process challenge on behalf of pregnant women. She claimed that mothers have a constitutional right to choose who attends their births. The court promptly dismissed her argument.

A more recent challenge was brought in Maryland in 1996. In Hunter v. Maryland, a constitutional right to privacy was again asserted on behalf of pregnant women. Arguing that privacy is a fundamental right, the plaintiff encouraged the court to apply a strict scrutiny test to Maryland’s statutory prohibition of midwifery. Again, citing Roe, the court held that privacy does not include a fundamental right to determine the circumstances surrounding birth. Thus, the statute only received rational basis review. Since the health and welfare of mother and infant are legitimate state interests, statutory bans on unlicensed midwives did not violate constitutional privacy rights.

C. Mother and Fetus: Competing Interests?

Judicial deference towards state legislatures is the reason why women’s privacy challenges have failed in the midwifery context. Because an infant is viable at the time of delivery, states may impose regulations that supersede a woman’s privacy rights. States simply express an interest in preserving health and life and Roe and Casey give courts power to enforce the state’s interest.

However, the judicial logic that promotes state interests over privacy rights in the midwifery context is flawed for several reasons. First, the judicial reliance on Casey’s viability test is faulty. Next, it is unreasonable for courts to equate the choice to abort with the choice of a direct-entry midwife as a birth attendant. Finally, the legislative goal of promoting the health and protecting the fetus is reached not by prohibiting direct-entry midwifery, but by licensing and regulating midwives.

A woman who chooses to carry her fetus to term and then deliver the baby with a direct-entry midwife’s assistance is expressing a preference for woman-centered care during labor and delivery. The woman does not consider the fetus a separate entity planted within her, but typically believes that the fetus is part of her and that both

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272 Id. at 1354.
273 Id.
274 Id.
276 Id. at 975.
277 Id. at 975-76.
278 Id. at 976.
279 Id. at 976.
share an important physical and emotional bond.\textsuperscript{280} Women that research birthing options and ultimately choose direct-entry midwives are making choices that reflect maternal and fetal interests. As this Note has already demonstrated in Part II, direct-entry midwives do not pose a heightened risk to mother or fetus when compared to physicians. Courts that equate abortion choices with the choice of a midwife-attended birth devalue midwives’ contribution to pregnancy and misunderstand midwives and their role in health care. Even scholars who advocate for limitations on reproductive rights note that control of the parturition is a monumental concern for women and should be recognized as a matter of ethics and policy.\textsuperscript{281}

More importantly, scientific studies conclude that women’s concern with the quality of birthing experiences influence birthing outcomes.\textsuperscript{282} Thus, the well-being of woman and child is directly related to the setting of birth\textsuperscript{283} and to a woman’s perceptions of her experience. Restricting women’s choice of birthing attendants and prohibiting direct-entry midwives may have other far-reaching consequences on the health of mother and child.

A healthy pregnancy exacts sacrifices and self-discipline from a mother.\textsuperscript{284} Ideally, the woman carries a child for forty weeks, avoids exposure to harmful chemicals, submits to frequent prenatal exams, abstains from drugs and alcohol, eats healthy food, exercises, avoids stress and prepares for the infant’s arrival.\textsuperscript{285} At the end of forty weeks, a woman that has sacrificed so much to keep a healthy child wants a normal delivery and healthy infant. A woman who chooses a direct-entry midwife to attend her delivery is not endangering the pregnancy and does not infringe on fetal rights.

In order to recognize that women’s choice of a direct-entry midwife as a birth attendant is a positive factor in birth, and not a conflict for the fetus, it is important to understand why women choose midwives. With most direct-entry midwives practicing in the outpatient or home birth setting, researchers asked Americans why they chose to have a midwife-attended birth at home.\textsuperscript{286}

\begin{itemize}
\item \textsuperscript{280} See Purdy, supra note 257, at 88.
\item \textsuperscript{281} John A. Robertson, Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth, 69 VA. L. REV. 405, 451 (1983).
\item \textsuperscript{282} Raymond DeVries et al., What (and Why) Do Women Want? The Desires of Women and the Design of Maternity Care, in BIRTH BY DESIGN: PREGNANCY, MATERNITY CARE, AND MIDWIFERY IN NORTH AMERICA AND EUROPE 243, 247 (Raymond DeVries et al. eds., 2001).
\item \textsuperscript{283} Id.
\item \textsuperscript{284} Purdy, supra note 257, at 91.
\item \textsuperscript{285} Id. at 90.
\item \textsuperscript{286} Boucher et al., supra note 7, at 119.
\end{itemize}
Twenty-four percent of women in the survey reported that their reason for a midwife-attended homebirth "was their belief that home was the safest place to give birth." Twenty-eight percent of women also said they preferred an intervention-free birth. One woman said "I realized that home . . . [is] a safer environment for my babies than a hospital room . . . . As far as I am concerned, lower intervention means higher safety for both mother and baby." Women in the study also reported wanting control of their birthing experience and a comfortable birthing environment.

Legislatures rarely interfere with any of the daily decisions during pregnancy, including decisions that may harm the fetus such as consuming alcohol, smoking or using illicit drugs. But when a woman attempts to make an informed judgment about birth attendant, state legislatures restrict the choice of midwives citing the maternal-fetal conflict and potential harm to the fetus. One bioethicist asks: "[h]ow can we begin to sort out the moral problems created by this situation?" She answers by saying that we must assume that women have at least the same basic rights as other people.

The rights to which the bioethicist alludes are the right to autonomy in healthcare decisions and the right to bodily integrity. Justice Ginsburg once wrote that challenges to abortion procedures "do not seek to vindicate some generalized notion of privacy . . . [but] center on a woman's autonomy to determine her life's course, and thus enjoy equal citizenship stature." Further, "eliminating or reducing women's reproductive choices is manifestly not a means of protecting them." Although this was written in the abortion context, its sentiment is true in all aspects of reproductive health. Restriction on autonomy for a purported state interest of preserving fetal life, especially when there is no danger to a fetus, denies women valued birthing experiences and deprives women "of the kind of control over how [women] live that [others] take for granted."

Researchers note that the style of midwives' care is well suited to the needs of pregnant women, especially in the low-risk healthy popu-
Midwives “give priority to providing women with good information, involving them in decision making, offering flexible and responsive care, supporting physiologic processes, and avoiding unnecessary interventions.” Intuitively, women seeking this type of care should be allowed to autonomously choose and access licensed midwives.

IV. RATIONAL BASIS REVIEW OF MIDWIFERY LAWS

Due process of law under the 14th Amendment is a constitutional guarantee of respect for personal liberties, rights and interests. This Amendment protects individuals from state abuse of power or errors in state judgment. When states choose to prohibit direct-entry midwives, instead of licensing and regulating them, states infringe on pregnant women’s interests. The legislature only allows pregnant women to choose among birthing options that the state has approved. When a pregnant woman challenges the law, the state argues that its police power permits the implementation of laws that protect public health. While states do have police powers, states do not have unrestricted power, especially where individual interests are at stake.

The rational basis test is the lowest level of scrutiny that a state’s actions must meet. Laws in this category must be rationally related to a legitimate state interest. A “law will be upheld unless [the state] has no legitimate purpose or the means used are not a reasonable way to accomplish the goal.” The means used are not reasonably related to the state goal when the government’s action is “clearly wrong, a display of arbitrary power, or an exercise of judgment.”

In prohibiting midwives, the purported state goal is public health and safety. This is a legitimate purpose. But the means used to achieve this purpose are not reasonably related.

Laws that prohibit all direct-entry midwives from practicing are substantially over-inclusive. Rational basis review tolerates some over-inclusiveness, but not significant over-inclusiveness. By generally prohibiting midwifery, states prevent the few incompetent

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296 SAKALA & CORRY, supra note 91, at 30.
297 Id.
298 U.S. CONST. amend. XIV, § 1.
299 ERWIN CHEMERINSKY, CONSTITUTIONAL LAW, PRINCIPLES AND POLICIES 677 (3rd ed. 2006).
300 Id. at 678.
301 Id.
midwives from practicing, but also prevent many more competent midwives from practicing. Since the vast majority of midwives pose little safety risk to the health of mother and baby as compared to physicians, the method chosen to prohibit midwives is significantly over-inclusive relative to the goal of safety. Every profession has a number of incompetent individuals—even the physician profession—but blanket laws are not used to prohibit physicians from practicing. Instead, state licensing laws are used to monitor competent practice.

Because blanket restrictions are not in place for other recognized medical groups, the prohibition of midwives is arbitrary. Midwives are an ancient profession that provided care to Americans for hundreds of years. Midwives practice extensively in every other country in the world. They are respected professionals. Equating midwives with voodoo practitioners or herbal healers is a mistake. Midwives are more similar to doctors, nurses, chiropractors and pharmacists. Exclusion of midwives from the category of licensed medical professionals is arbitrary.

Finally, prohibiting midwifery is an exercise of poor judgment by states. The research discussed in Part II demonstrates that midwifery is safe for mothers and infants. Midwives are skilled, educated, trained and effective practitioners in the low-risk population. Midwives’ practice can help reduce soaring rates of intervention-related complications, maternal and infant mortality and intervention-associated costs. Finally, midwives can reduce the obstetric care disparity between ethnic groups and socioeconomic classes of women. States that continue to prohibit midwives are not achieving health goals. Evidence-based maternity research concludes that midwives are integral to reforming maternity care in the United States.

V. PROPOSAL FOR STATE STATUTORY EXEMPTIONS FOR DIRECT-ENTRY MIDWIVES

Throughout this Note I have argued that it is imperative to expand direct-entry midwifery practice to all fifty states. Women in the United States should be able to choose a physician or a midwife for pregnancy care and delivery. Ultimately, the United States would benefit from encouraging women to partake in a dual system of maternity care where midwives provide the majority of care to low-risk pregnant women and obstetricians focus on high-risk complicated cases. Both groups would support each other and refer patients to the other practitioner when appropriate.

The first step that needs to be taken to achieve this type of maternity system is the expansion of midwifery to all fifty states. Because only a handful of states still prohibit direct-entry midwives from prac-
My proposals aim to enact statutes that legalize direct-entry midwifery and implement an infrastructure to regulate and monitor the midwives’ activities in all fifty states. My proposals are inspired in part by Washington State’s midwifery model for licensing and regulation.304

Legislatures should enact a baseline licensing mechanism for direct-entry midwives. It is important that direct-entry midwives be licensed rather than just certified by a national group or given permits by local health departments. The state statutes should allow licensed direct-entry midwives to practice in the hospital, outpatient birth center and home settings.

Next, I suggest that states use the North American Registry of Midwives (NARM) certification process as a prerequisite for licensing. The NARM certification, as opposed to the American College of Nurse-Midwives (ACNM), creates a national standard for education, skill and safety but recognizes that all direct-entry midwives do not enter into midwifery education and practice from a baccalaureate degree program.305 NARM certification requires that all midwives, regardless of university training or apprentice training, achieve skills and gain experiences that are essential to safe practice.

Legislatures should also establish a Midwifery Licensing and Regulating Council, which would comprise of one obstetrician, one certified nurse-midwife, two certified-midwives and two lay citizens. The professional make-up of this council would allow for adequate representation of interests and should foster a sense of cooperation rather than competition between the professions. This council should be empowered by the legislature and shall assume responsibility for oversight of midwives, development of practice standards, and creation of standards that coordinate inter-disciplinary care for complicated pa-

304 See WASH. REV. CODE ANN. § 158.50.010 (West 2010).
305 These values are reflected in NARM’s mission statement for the certification process.

NARM’s mission is to offer and maintain an evaluative process for multiple routes of midwifery education; to develop and administer a standardized examination system leading to the credential “Certified Professional Midwife” (CPM); to identify best practices that reflect the excellence and diversity of the independent midwifery community as the basis for setting the standards for the CPM credential; to publish, distribute and/or make available materials that describe the certification and examination process and requirements for application; to maintain a registry of those individuals who have received certification and/or passed the examination; to manage the process of re-certification; and to work in multiple arenas to promote and improve the role of CPMs in the delivery of maternity care to women and their newborns.

How to Become a NARM Certified Professional Midwife (CPM), supra note 137.
tients. The most important function of the council should be the drafting of scope of practice standards that preserve midwives’ core model of care for low-risk patients but incorporate obstetricians’ highly specialized skill for consultation and collaboration with the more complex cases. The council will define what constitutes a low-risk and high-risk pregnancy within each state.

This council should also be able to conduct disciplinary hearings when midwives violate guidelines or complaints are filed against midwives. After conducting an administrative hearing and giving the midwife an opportunity to explain and defend against allegations, the council may discipline the midwife through formal sanctions, including temporary suspension or permanent revocation of licenses.

In order to decrease costs and recruit midwives to work in the state, legislatures must also address the reimbursement structure. Medicaid and other state assistance programs should add licensed midwives to the list of reimbursed providers. The reimbursement amount should adequately reflect midwives’ education, specialized training and cost of living. Reimbursement should not be contingent upon location, such as hospital versus home, but should require appropriate documentation of services rendered. Legislatures then should encourage private insurers to establish a similar reimbursement scheme.

Midwives should have responsibilities as well. All licensed midwives would be required to follow scope of practice guidelines and only care for patients deemed low-risk by the state midwifery council. Midwives would need to carry malpractice insurance. Before rendering any services to a woman, the midwife should document informed consent from the woman. The informed consent should follow the same guidelines that physicians use: diagnosis, risks, benefits and alternatives. Upon rendering care, direct-entry midwives would need to document treatment as deemed necessary by the Midwifery Licensing and Regulating Council and furnish documents for review upon request.

As professionals, licensed midwives would have all the rights that licensing provides but would also have responsibilities. Midwives should form local professional societies that represent their interests. Research about midwifery should also be ongoing. Such research could validate the impact of midwifery and ensure patient safety. Finally, licensed midwives must be responsible for completing all continuing education requirements that are necessary for preserving their ongoing skill and knowledge, and maintaining their license.
CONCLUSION

Direct-entry midwifery has re-established itself in the United States. Americans have a renewed interest in midwifery. Midwives have special skills and experiences to offer women. With appropriate legal structure, education and professional development, midwifery can readily be expanded in the United States.

Policymakers must move beyond the traditional notions of birth provided by the medical community. States prohibiting direct-entry midwifery are abusing licensing powers. But an easy remedy is available to allay concerns regarding health and safety-licensure and regulation of direct-entry midwifery.

Courts and legislatures must also recognize that reproductive rights encompass women's dignity, autonomy and bodily integrity during pregnancy and the birthing process. Women choosing safe alternative birth practices should no longer be categorized with women choosing abortion, and statutory obstacles to achieving a safe, satisfying birth experience must be removed.

Finally, courts should rule that state statutes that prohibit direct-entry midwives do not pass rational basis scrutiny. The laws are at odds with current research, are not reasonably related to the state goal of public health and are an arbitrary abuse of legislative power. Courts should realize that "[t]he longstanding tradition of imposing such burdens on women does not strengthen the law's claim to constitutional legitimacy and may instead weaken it . . . ."306

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