MAKING THE MIDWIFE IMPOSSIBLE: HOW THE STRUCTURE OF MATERNITY CARE HARMS THE PRACTICE OF HOME BIRTH MIDWIFERY

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> If the profession would realize that parturition [childbirth] viewed with modern eyes is no longer a normal function, but that it has imposing pathologic dignity, the midwife would be impossible even of mention.
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> - "Titan" of Twentieth Century Obstetrics, Dr. Joseph DeLee, 1915[1]

In the following pages, I will demonstrate how the present-day structure of maternity care diminishes the viability of home birth midwifery as a profession and as a consumer choice. I aim to illustrate how the administrative, regulatory, and legal status quo make home birth midwifery "'impossible even of mention.'"[2] Other sources have explained some of the facets of the law as it relates to childbirth,[3] and many childbirth professionals know how the law impacts and constrains their choices/lives.[4] By providing an overview of how the maternity care system eliminates home birth midwives from its pool of viable care providers, this paper demonstrates the fiction of consumer choice. People cannot choose home birth or hospital birth like they choose between Pepsi and Coke. In fact, the system necessitates certain choices and eliminates others.[5] Ultimately,

[1] JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 25 (1997) (quoting Joseph B. DeLee, *Progress Toward Ideal Obstetrics*, 73 AM. J. OBSTETRICS & DISEASES WOMEN & CHILD. 407, 410 (1915)).

[2] *Id.*

[3] *See e.g.*, SHEENA MEREDITH, POLICING PREGNANY: THE LAW AND ETHICS OF OBSTETRIC CONFLICT 5-37 (2005); *see generally* ANDREW SYMON, RISK AND CHOICE IN MATERNITY CARE: AN INTERNATIONAL PERSPECTIVE (2006); Sylvia A. Law, *Childbirth: An Opportunity for Choice that Should be Supported*, 32 N.Y.U. REV. L. & SOC. CHANGE 345 (2008); Rebecca Spence, *Abandoning Women to their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights*, 19 CARDOZO J.L. & GENDER 75 (2012); Lynn Paltrow & Jeanne Flavin, *Arrests of and Forced Interventions on Pregnant Women in the United States, 1973–2005: Implications for Women's Legal Status and Public Health*, 38 J. HEALTH POL. POL'Y & L. 299 (2013).

[4] MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE (Robbie Davis Floyd, Christine Barber Johnson Eds., Routledge 2006)[hereinafter MAINSTREAMING MIDWIVES].

[5] Nancy Ehrenreich, *Colonization of the Womb*, 43 DUKE L.J. 492, 509 (1993); RICKIE SOLINGER, A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA 158 (2005); THE REPRODUCTIVE RIGHTS READER: LAW, MEDICINE, AND THE CONSTRUCTION OF MOTHERHOOD 4 (Nancy Ehrenreich ed., 2008).

I hope this paper provokes a reconsideration of the ways the profession of midwifery is constrained and the impact of that constraint on the ecology of birth.

The reader should know that in the United States there are primarily two different kinds of midwives, those that come to midwifery through nursing and those that come to midwifery directly.[6] Today, nurse-midwives (who have the "Certified Nurse Midwife/CNM" credential and are often just called "midwives") have gained substantial credibility as maternity care providers and are regulated in all fifty states.[7] The role of CNMs, while still contested within the hierarchical framework of medicine, is more secure within the health care industry than non-nurse midwives.[8]

This paper focuses on the kind of midwife who does not have credibility or security within the maternity care industry. These direct-entry midwives work exclusively outside of hospitals in homes and freestanding birth centers.[9] They are experts in non-medicalized, physiologic childbirth.[10] Unlike CNMs their training is based out- of the hospital (though their training is hospital based, some CNMs also elect to work outside of hospitals).[11] For the purposes of this paper I will refer to direct-entry midwives, many of whom have the Certified Professional Midwife (CPM) credential,[12] as "midwives" or "home birth midwives" because it is descriptive, it locates the place of the midwife's practice, and distinguishes her care from hospitalized maternity care.

This paper considers three legal structures that significantly impact maternity care.[13] The first structure is administrative, the second is professional, and the third structure concerns liability. The administrative structure of maternity care is impacted by agencies and regulations at both

[6] ROOKS, *supra* note 1, at 21-25.

[7] *Id.* at 161.

[8] *See e.g.*, Ranjana Srivastava, *Speaking Up — When Doctors Navigate Medical Hierarchy*, 368 NEW ENG. J. MED. 302 (2013); *see also Essential Facts about Midwives*, AM. C. NURSE – MIDWIVES (July, 2013) http://midwife.org/Essential-Facts-about-Midwives.

[9] *See What is a Midwife?*, MIDWIVES ALLIANCE N. AM., http://www.mana.org/about-midwives/what-is-a-midwife (last visited Mar. 12, 2014); *see also* MIDWIVES ALLIANCE N. AM., CERTIFIED PROFESSIONAL MIDWIVES IN THE UNITED STATES: AN ISSUE BRIEF 1, 3 (2008), *available at* http://mana.org/pdfs/CPMIssueBrief.pdf.

[10] *See* CERTIFIED PROFESSIONAL MIDWIVES IN THE UNITED STATES: AN ISSUE BRIEF, *supra* note 9, at 2.

[11] *See Comparison of Certified Nurse-Midwives, Certified Midwives, and Certified Professional Midwives*, AM. C. NURSE-MIDWIVES (Aug. 2011), http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000268/CNM%20CM%20CPM%20ComparisonChart%20082511.pdf.

[12] *See What is a CPM*, NARM, http://narm.org/ (last visited Mar. 12, 2014).

[13] Constitutional law also impacts maternity care, but mostly when it comes to preventing or terminating pregnancy (as demonstrated by the *Roe* line of cases). *See generally* Roe v. Wade, 410 U.S. 113 (1973); Planned Parenthood v. Casey, 505 U.S. 833 (1992); Gonzales v. Carhart, 550 U.S. 124 (2007). It has not yet played a significant role in shaping the maternity care industry.

the state and federal level.[14] The professional structure is impacted by state statutes that dictate the scope of practice of a profession (along with state and national membership organizations that lobby to expand or constrain that scope).[15] The liability structure is dictated by state common law as well as the insurance industry (which is also regulated at the state level), and determines the standard of care certain professions owe to their clients; who can be liable for harm, and to what extent. In the following sections covering the administrative, professional, and liability structures, I will explain how together they make home birth midwifery "impossible even to mention," which means that both potential consumers and potential midwives are constrained in their choices.

THE ADMINISTRATIVE STRUCTURE: HOW HEALTH CARE IS BUILT

For the most part, the way reproductive care is distributed and shaped is not governed by codes or cases.[16] Instead, it is governed by regulations, policies, and administrative decisions, which often develop under less public scrutiny than major court cases and laws.[17] While many agencies within the administrative/regulatory structure impact reproductive health,[18]

[14] *See Legal Status of US Midwives*, MIDWIVES ALLIANCE OF N. AM., http://www.mana.org/about-midwives/legal-status-of-us-midwives (last visited Apr. 9, 2014); *see also* 42 U.S.C. §300gg-5(a) (2006) (describing non-discrimination in healthcare as to providers); *Healthcare Law*, MIDWIVES ALLIANCE OF N. AM., http://www.mana.org/healthcare-policy/healthcare-law (last visited Apr. 9, 2014) (providing important federal acts and case law concerning the administrative structure of maternity care).

[15] *See generally* BARRY ALEXANDER ET AL., AHLA FUNDAMENTALS OF HEALTH LAW (4th ed. 2008).

[16] Note that the ACA may be the recent exception establishing for the first time that maternity care is an "essential benefit." *See ObamaCare Essential Health Benefits: What Are Essential Health Benefits?*, OBAMACARE FACTS, http://www.obamacarefacts.com/essential-health-benefits.php (last visted May 16, 2014). As previously mentioned, key cases impacting reproductive health care are based on abortion and contraception; but with eighty percent of the childbearing population eventually giving birth, neither contraception nor abortion impact that part of reproductive health care. *See* Gretchen Livingston & D'verga Colon, *Childlessness Up Among All Women: Down Among Women with Advanced Degree*, PEW RESEARCH CTR. (June 25, 2010), http://www.pewsocialtrends.org/2010/06/25/childlessness-up-among-all-women-down-among-women-with-advanced-degrees/.

[17] *See* Rust v. Sullivan, 500 U.S. 173 (upholding regulations limiting the use of Title X funds for family planning services); Exec. Order No. 13535, 75 Fed. Reg. 15599 (Mar. 24 2010) (executive order pursuant to the "Patient Protection and Affordable Care Act" to "establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered)"); 45 C.F.R. §§ 88.1-88.2 (2008) (regulations during Bush administration intended to strengthen projections for "health care entities . . . to refuse to perform health care services . . . which they may object [to] for religious, moral, ethical, or other reasons.").

[18] *See e.g.*, PROGRAM ON REPROD. HEALTH AND THE ENV'T, SHAPING OUR LEGACY: REPRODUCTIVE HEALTH AND THE ENVIRONMENT 1 (Sept. 2008) (describing the role of the Environmental Proection Agency and Food & Drug Administration in regulating exposure to chemicals which may impact reproductive health); Announcement of Public Workshop, "Examining Health Care Competition," 79 Fed. Reg. 101053 (Feb. 24, 2014), *available at*

I will use the Department of Health and Human Services (DHHS) and the National Institute of Health (NIH) as examples. These institutions are often connected with similar state level agencies through federal funding and thus illuminate how the administrative system shapes maternity care.[19]

There are eleven agencies and dozens of offices under the Department of Health and Human Services.[20] It has more than 100 programs and is one of the biggest agencies in the government.[21] It handles a billion insurance claims, insures one in four Americans, and provides more grant funds than any other agency.[22] Agencies housed by DHHS include: the Center for Disease Control (CDC), the Centers for Medicare and Medicaid Services (CMS), the Food and Drug Administration (FDA), the Indian Health Service, and the National Institutes of Health.[23] DHHS and many of these other agencies evolved over time from various initiatives and programs, but the foundation of public health administration in the United States dates back to 1798 with the passage of an act that provided care to disabled seamen, which continues today with other similar initiatives.[24]

It is notable that the Surgeon General is so named because the position came out of the Marine Hospital Service; the provision of public health in general originated in a military context, and many of the initial projects were linked to defense objectives.[25] The DHSS, as we know it today, was established as a cabinet-level department in 1953 as the "Department of Health, Education and Welfare," or HEW; however, the Department of Education was established in 1979, and so HEW became DHHS in 1980.[26] Though the role of public health has been expanding beyond the military context since its inception, it was not until the 1960's that women and children were specifically included in projects and funding.[27]

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https://ftcpublic.commentworks.com/ftc/healthcareworkshop.pdf (Federal Trade Commission announcement on workshop to understand dynamics of healthcare).

[19] *See generally* ALEXANDER, *supra* note 15.

[20] *HHS Organizational Chart*, U.S. DEP'T OF HEALTH & HUM. SERVICES, http://www.hhs.gov/about/orgchart/ (last visited Apr. 10, 2014).

[21] *HHS Program Inventory*, U.S. DEP'T OF HEALTH & HUM. SERVICES, http://www.hhs.gov/budget/2013-program-inventory/program-inventory-introduction.html (last visited Apr. 10, 2014); *see also Contact Us*, OFFICE OF INSPECTOR GENERAL, http://wwww.oig.hhs.gov/contact-us (last visited Apr. 10, 2014)("The Office of Inspector General is at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 400 other U.S. Department of Health & Department of Health & Human Services programs.").

[22] *HHS Programs and Services*, U.S. DEP'T OF HEALTH & HUM. SERVICES, http://www.hhs.gov/about/programs/index.html (last visited Apr. 10, 2014).

[23] *Operating Divisions*, U.S. DEP'T OF HEALTH & HUM. SERVICES, http://www.hhs.gov/about/foa/opdivs/index.html (last visited Apr. 10, 2014).

[24] *Historical Highlights*, U.S. DEP'T OF HEALTH & HUM. SERVICES, http://www.hhs.gov/about/hhshist.html (last visited Apr. 10, 2014).

[25] *Id.*

[26] *Id.*

[27] *Id.*

The NIH "is the steward of medical and behavioral research for the Nation."[28] This mission evolved out of a number of initiatives in public health throughout the country's history.[29] In 1879, the National Board of Health began as the first coordinated "national medical research effort," and in 1887 the Laboratory of Hygiene (later renamed Hygienic Laboratory) was created for the study of infectious diseases.[30] In 1912, the research agenda was "expanded to include other-than-communicable diseases[,] field investigations, navigable stream pollution, and information dissemination."[31] These agencies set the agenda for medical research and resource distribution.[32] Issues linked to military safety and infectious disease developed first, and as a result the entire medical infrastructure was informed by these priorities.[33]

In 1918, the connection between scientists and the federal government was solidified with the Chamberlain-Kahn Act providing grants to scientists for the study of venereal disease; this precedent was expanded in 1930 when the Ransdell Act created a system of fellowships and renamed the Hygienic Laboratory as the National Institute of Health.[34] Controlling the spread of disease was an early priority of the medical infrastructure, not supporting the natural processes of a healthy population.[35] It is within this context that the present day maternity care system developed and excluded home-birth midwives who had different expertise.[36] The 1935 Social Security Act provided grants to states to prevent the interstate spread of disease and improve local public health programs.[37]

That same year was the first year that place-of-birth statistics were kept, and 36.9% of births were in the hospital; by 1955, the rate had climbed to 99%, where it remains to this day.[38] The increase in access to hospitals was related to the 1946 Hill-Burton Act, which provided for building and surveying public health facilities, further developing the health care infrastructure of the country, leaving midwives behind.[39] It was not until 1963 that services to pregnant women were funded by The Maternal and

[28] *About the NIH*, NAT'L INST. OF HEALTH, http://www.nih.gov/about/almanac.htm (last visited Mar. 24, 2014).

[29] *Chronology of Events*, NAT'L INST. OF HEALTH, http://nih.gov/about/almanac/historical/chronology_of_events.htm (last visited Mar. 24, 2014) [hereinafter *Chronology of Events*].

[30] *Id.*

[31] *Id.*

[32] *See id.*

[33] *See id.*

[34] *Id.*

[35] *Historical Highlights*, *supra* note 24.

[36] ROOKS, *supra* note 1, at 22.

[37] 42 U.S.C. § 1396-1 (2006).

[38] *See* RICHARD WERTZ AND DOROTHY WERTZ, LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA, 132-35 (1989); *see also* MARIAN F. MACDORMAN, ET AL., TRENDS IN OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES, 1990–2012 (2014).

[39] *Chronology of Events*, *supra* note 29.

Child Health and Mental Retardation Planning Amendments of the 1963 Social Security Act, well after hospital based maternity care had been in place.[40] There is a misperception that hospitalized maternity care replaced home-based maternity care because it was better or safer, however, this is not indicated by the research, maternity care was swept up in and inadvertently shaped by the industrialization of medicine.[41]

This service infrastructure was bolstered by a research infrastructure which was improved through the establishment of a "central data processing facility" in 1954 and the establishment of a "Computation and Data Processing Branch in the Division of Research Services" in 1960.[42] The research infrastructure was similarly disinterested in maternity care, and maternity care was similarly impacted by research into disease. Home-birth midwives did not have the resources to develop and execute a research agenda that would establish their methods and theories for working with primarily healthy women during a normally healthy process.[43] By the time programs like the 1963 Maternal and Child Health and Mental Retardation Planning Amendments included grants for research, home-birth midwives were already attending to less than 1% of the population.[44] It was not until 1990 that the Office of Research on Minority Health and the Office of Research on Women's Health were established and extended through the Women's Health Research and Prevention Amendments of 1998.[45] Women's health was never a priority in the development of the health care infrastructure that contains maternity care today, and home-birth midwives were never taken into account.[46]

These are just two examples of agencies that impact the health infrastructure of the country in small and large ways; including setting the agenda for facilities, research and funding in a context that ignores and devalues women's health and non-medical care providers.[47] In addition, the Centers for Medicare and Medicaid Services (CMS) has had a huge impact on health care in this country.[48] "Medicare Conditions of Participation" effectively license health service facilities.[49] Since many providers need the

[40] *Chronology*, SOC. SEC. ADMIN. http://www.ssa.gov/history/1960.html (last visited Apr. 10, 2014).

[41] In fact, early studies demonstrated that medicalized maternity care was less safe. ROOKS, *supra* note 1, at 28-29.

[42] *Chronology of Events*, *supra* note 29.

[43] ROOKS, *supra* note 1, at 26-27.

[44] *Chronology of Events*, *supra* note 29.

[45] *Id.*

[46] ROOKS, *supra* note 1, at 447-96.

[47] *Id.; see also* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE: THE RISE OF A SOVERIGN PROFESSION AND THE MAKING OF A VAST INDUSTRY 21-22 (1982); NORMAN GEVITZ, OTHER HEALERS: UNORTHODOX MEDICINE IN AMERICA (1988).

[48] *See* ALEXANDER, *supra* note 15.

[49] John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agendas*, 53 BUFF. L. REV. 459, 461-62 (2005).

income from government programs in order to be salient, they will use these federal regulations for the basis of their own standards.[50] Federal "reimbursement policies [] have acted both to promote, alter and end operational practices, touching on all matters of the institution's business."[51] Once midwives were excluded from this infrastructure, they became almost invisible to it. Today, funding provided through Medicare under the American Recovery and Reinvestment Act for health information technology is made available only to certain health care professionals, excluding home birth midwives.[52] Similarly, the National Health Service Corps offers a loan repayment program to health care professionals who work with under-served populations, however, this program is not available to home birth midwives.[53]

Agencies, like the Office of Management and Budget, have a less direct, but nonetheless significant impact on the health care system by promulgating things like "Directives for the Conduct of Federal Statistical Activities."[54] These statistical directives do not so much impact hospital policy, budgets, or protocols, but they certainly impact the shape of knowledge derived from data collection and the kinds of data that is collected. As the National Information Center on Health Services Research and Health Care Technology (NICHSR) explains:

> [b]irths, deaths, marriages, and divorces are recorded by state government authorities as they occur. The certificates they issue are the source of information about the conditions of each. This data is compiled by states and reported to the NCHS [National Center for Health Statistics] which issues reports based on it.[55]

If a person is not included in the data, they will not be included in the reports. This data is used by other agencies, scientists and policy makers to make decisions about the distribution of resources, the standard of care, and even what questions are worth investigating.

Until the 2003 federal revision in birth certificates, home birth midwives were not specifically listed or tracked on birth certificates, nor

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[50] *Id.* at 461.

[51] *Id.*

[52] *Economic Stimulus Funding Provides Millions for Nursing Education and Jobs*, ROBERT WOOD JOHNSON FUND. (Mar. 24, 2009), http://www.rwjf.org/en/about-rwjf/newsroom/newsroom-content/2009/03/economic-stimulus-funding-provides-millions-for-nursing-educatio.html.

[53] *Loan Repayment Programs*, NAT'L HEALTH SERV. CORPS, http://nhsc.hrsa.gov/loanrepayment/ (last visited Apr. 14, 2014).

[54] Standards for the Classification of Federal Data on Race and Ethnicity, 59 Fed. Reg. 29831 (June 9, 1994).

[55] *Vital Records*, U.S. NAT'L LIBRARY OF MEDICINE, http://www.nlm.nih.gov/nichsr/usestats/vital_records.html (last updated Jan.3 2008); *see also Birth Data*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/births.htm (last updated Mar. 24, 2014) ("[i]n the United States, State laws require birth certificates to be completed for all births, and Federal law mandates national collection and publication of births and other vital statistics data.").

were planned home births.[56] Clearly, these statistics "reflect[] the expectations of the people who established the institutions that collect the information" and provide "a distinct view of health correlates, conditions, care and consequences."[57] Home-birth midwives, and non-medical childbirth, were not included in the expectations of the people who established the institutions, and therefore, the institutions help to make those midwives, literally, impossible even to mention. In some states even the birth certificates for people who were born at home have been questioned.[58]

The administrative structure helps to constrain maternity care. Often, it comes down to what options are listed on agency forms and whether people believe they have a choice about how to comply. Because of the interaction between state and federal agencies, and the different ways states organize, it would be difficult to point out all of the forms and policies that combine to constrain consumer and professional choice in maternity care. Building codes and licensing schemes required for federal funding are subtle; the funding for hospitals and roads, and student incentives have a more pervasive impact. However, when literally everyone is channeled through the same system, and the boxes on the form provide no option for refusing medical maternity care or selecting a midwife at home, the option becomes almost impossible to choose.

THE PROFESSIONAL STRUCTURE: THE SCOPE OF HEALTH CARE PROVIDERS

Professionalization of midwives began in France in the 1560's and spread throughout Europe despite attempts at control by the Catholic Church.[59] Religious oversight was particularly strong and enduring in England, this, combined with the development of obstetrics, caused a 19th century decline in midwifery.[60] The negative affects of a maternity care system lacking midwives were noticed and addressed with government

[56] *See The New Birth Certificate: Making Vital Statistics More Vital*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nchs/ppt/dvs/THE%20NEW%20BIRTH%20CERTIFICATE.ppt. When the new birth certificates were developed they were tested by hospitals but not home birth midwives. This is just another example of how home birth midwives are outside of the infrastructure in ways that diminish their viability.

[57] *Sources of Health Statistics*, U.S. NAT'L LIBR. OF MED. SOURCES, http://www.nlm.nih.gov/nichsr/usestats/index.html (last visited Mar. 24, 2014); *see also* CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 55.

[58] Miriam Jordan, *They Say They Were Born in the U.S.A. The State Department Says Prove It: An Old Scan Casts Doubt on the Citizenship of Texans Delivered by Midwives*, WALL ST. J. (Aug. 11, 2008) online.wsj.com/news/articles/SB121842058533020890 7.

[59] ROOKS, *supra* note 1, at 13-14 (stating that half of the women killed during the Inquisition and related witch hunts were midwives, resulting in approximately 25,000 midwives being killed during the 1500's).

[60] Obstetrics and Midwifery, ENCYCLOPEDIA OF CHILDREN AND CHILDHOOD IN HISTORY AND SOC'Y, http://www.faqs.org/childhood/Me-Pa/Obstetrics-and-Midwifery.html (last visited May 19, 2014).

support, allowing the professionalization of European midwives to continue throughout the 19th and 20th centuries.[61]

At the dawn of the 20th century, midwifery in the United States varied greatly from one community to another. In the south there was a strong history of "granny midwives" providing care mostly to African-American women and, in the southwest, Parteras provided midwifery care to much of the Hispanic population.[62] American Indian midwives performed birthing rituals as varied as the tribes.[63] Immigrant women, educated in their home countries brought midwifery with them to this continent. Many were well-regarded professionals in Europe, but here, lacked a system of professionalization, faced language and cultural barriers and access to other midwives.[64]

At this same time, medicine in the United States varied greatly from one community to another as well. Doctors organized to promote the development of standards and the advancement of their profession, and the American Medical Association (AMA) was founded in 1847.[65] Doctors often had more economic and political power than midwives and faced less barriers to organizing.[66] In addition, where in Europe midwifery developed alongside medicine, in the United States midwifery was seen as a threat.[67] In 1913, the "AMA establishe[d] a Propaganda Department to gather information" about competing health care providers and developed a campaign to eliminate midwifery in the 1920's.[68] Doctors established themselves at the center of health care by defining "medical practice extremely broadly" in Medical Practice Acts of every state.[69] As a result, laws regulating other kinds of health care providers would have to define themselves in relation to medicine, and define themselves as something

[61] ROOKS, *supra* note 1, at 13-14 (discussing the improved training and regulations of Parisian midwives).

[62] Judith Rooks, *The History of Childbearing Choices in the United States*, Our Bodies Ourselves, http://www.ourbodiesourselves.org/book/companion.asp?id=21&compID=75 (last updated Jan. 2013) [hereinafter *History of Childbearing*]; Cordelia S. Hanna-Cheruioyot, *A Brief History of Midwivery in America*, ASS'N FOR WHOLISTIC MATERNAL & NEWBORN HEALTH PROMOTING MOTHER-BABY FRIENDLY MATERNITY CARE, http://wholisticmaternalnewbornhealth.org/professional-education/history-of-midwifery/.

[63] *Midwives and Native Women* (Native America Calling radio program July 17, 2008), *available at* http://www.nativeamericacalling.com/ram/nac_past2008a.shtml#july; *see also History of Childbearing*, *supra* note 62.

[64] ROOKS, *supra* note 1, at 21-24; *see also* WERTZ, *supra* note 38, at 47.

[65] *AMA History Timeline*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/about-ama/our-history/ama-history-timeline.page (last visited Apr. 8, 2014); *see* also ROOKS, *supra* note 1, at 21.

[66] ROOKS, *supra* note 1, at 21.

[67] *Id.*

[68] *AMA History Timeline*, *supra* note 65; ROOKS, *supra* note 1, at 22-26 (describing the campaign to eliminate midwives).

[69] ROOKS, *supra* note 1, at 21.

other than "the practice of medicine."[70] This allowed the state to prosecute any providers not licensed as doctors for the illegal practice of medicine.[71]

One of the first cases to establish midwifery as the illegal practice of medicine was *Commonwealth v. Porn*.[72] Hanna Porn offered midwifery services to the working class Finnish, Russian and Swedish immigrants in her community for "a third of what legal doctors charged" and with half the infant mortality rate.[73] She became a target of the campaign to eliminate midwifery and was charged with the illegal practice of medicine.[74] The trial court held that "obstetrics as a matter of common knowledge has long been treated as a highly important branch of the science of medicine" and therefore, despite the fact that "childbirth [was] not a disease," it still fell under the auspices of doctors.[75] This case coincided with the nationwide trend promulgated by the AMA to define medicine to the exclusion of all other health care providers and to place doctors at the center.[76]

Despite efforts to exclude them, midwives found ways to carve out a place for themselves, even if it was under doctors in the hierarchy.[77] At first, nurse-midwives in the U.S. were perceived by doctors with the same animus as other midwives and were excluded from hospitals where more and more births were taking place.[78] However, after World War II "large amounts of federal and state money" went into building hospitals, increasing access for rural citizens and the urban poor.[79] Physicians became overwhelmed and unable to meet the demand, leading to nurse-midwives

[70] *Contra id.*(pointing to a catch-22 inherent in this system but an analysis of that catch-22 is beyond the scope of this article).

[71] ROOKS, *supra* note 1, at 21.

[72] Commonwealth v. Porn, 82 N.E. 31 (Mass. 1907).

[73] *Id.* at 31; Eugene R. Declercq, *The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts*, 84 AM. J. PUB. HEALTH 1022, 1023-24 (1994).

[74] *See* Porn, 82 N.E. at 31-32.

[75] Porn, 82 N.E. at 31. (holding that even though Porn was "a woman of good character and reputation" the statute could not be considered unconstitutional because "[t]he maintenance of a high standard of professional qualifications for physicians is of vital concern to the public health, and reasonable regulations to this end do not contravene any provision of the State or federal Consitution"). As far as common language is concerned, the word obstetrician was less than a hundred years old at the time of Porn's case. *See generally* Adrian E. Feldhusen, *The History of Midwivery and Childbirth in America: A Time Line*, MIDWIFERY TODAY, http://www.midwiferytoday.com/articles/timeline.asp (last visited Apr. 8, 2014).

[76] Declercq, *supra* note 73, at 1022.

[77] In many states the Board of Medicine issued licenses to midwives. ROOKS, *supra* note 1, at 64.

[78] ROOKS, *supra* note 1, at 41-42. "'[T]o the vast majority of obstetricians the very word midwife is anathema, whether or not it is coupled with the term nurse'" said Dr. Nicholas Eastman in 1955, when the first mainstream hospital allowed nurse-midwifery trained personnel to assist. They used "the term . . . 'obstetric assistants'" for these personnel due to this animus and the fact that the term denoted "'the main function which we would envisage for such nurses, namely, the rendering of skilled assistance to obstetricians.'" At the same time, the American Nurses Association and the National League for Nursing both thought midwifery was part of medicine and did not formally recognize midwifery or midwives until 1968 when it was recognized as a specialty within nursing.

[79] *Id.* at 42.

starting to be seen as a "source of relief," instead of a threat.[80] Between 1950 and 1970, federal money was directed at developing nurse-midwifery to meet this need. Additionally, mainstream medical schools started nurse-midwifery programs and nurse-midwives started practicing in hospitals.[81]

Nurse-midwives started like other midwives as independent care providers, but with a nursing background.[82] In the hospital setting, nurse-midwives became "mid-level" care providers carefully constrained by physicians.[83] The profession has been caught in the middle of the medical hierarchy, with greater independence coming as demand increased. In response to physician shortages in "rural and inner-city areas" in the 1960's, "two new categories of health care providers" were defined: nurse practitioners and physician assistants.[84] These care providers have more autonomy than before but are still defined in relationship to doctors, whom remain at the center of medicine.[85] "Most nurse-midwives now practice under laws that regulate nurse practitioners."[86]

Home birth midwives, who are not nurse practitioners, have resisted becoming a part of the medical hierarchy, partly because they do not see their work as medical.[87] The cost has been that several states still explicitly prohibit them.[88] Twenty-eight states explicitly allow for licensure, certification, registration or permits for home birth midwives.[89] The rest vary, with midwifery being illegal, "legal by judicial interpretation or statutory inference . . . not legally defined, but not prohibited," or "legal by

[80] *Id.* at 43.

[81] *Id.* at 42-43.

[82] *Id.* at 43.

[83] In contrast to the first nurse-midwifery programs like the Frontier Nursing Service which was owned and operated exclusively by nurse-midwives for decades starting in the 1930's, nurse-midwives today are constrained by the same fear of competition and animus for midwives that fueled the separation of nurse-midwifery from midwifery in the first place. In the 1980's and 1990's, doctors' professional organizations fought to maintain their stature and their market by constraining the practice of nurse-midwives. In 1980 the American Academy of Family Physicians formally "oppos[ed] nurse-midwifery licensure," and in 1985, the American Medical Association fought legislation that would allow nurse-midwives to practice independently. The American College of Obstetricians and Gynecologists feared independent nurse-midwifery and sought to keep obstetricians at the top of the maternity care team. *Id.* at 82-83.

[84] *Id.* at 51.

[85] *Id.* at 51-52 (describing the type of work that "[o]bstetric and gynecologic nurse practitioners" could perform; "Most [laws] required significant degrees of physician involvement, ranging from direct supervision to written agreements").

[86] ROOKS, *supra* note 1, at 52, 162. Nurse midwifery is legal and regulated in all fifty states where the profession is generally defined "as 'the independent management of women's health care focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and genealogical needs of women."

[87] *Id.* at 230.

[88] *Id.*

[89] PushGirl Friday, *Certified Professional Midwives (CPMs) Legal Status By State*, THE BIG PUSH FOR MIDWIVES (Aug. 29, 2013), http://pushformidwives.org/cpms-by-state/.

statute, but licensure unavailable."[90] Without licensure or a clear path to professionalization midwives in twenty-two states can face criminal prosecution for practicing nursing or medicine without a license.[91] Criminal prosecution is not just an archaic possibility in these twenty-two states; midwives are still prosecuted under these laws.[92]

In the states where home birth midwives face criminal prosecution, the practice comes with risks for practicing midwives, consumers, potential consumers and potential midwives.[93] The risks for the midwives are straightforward; they face the costs, loss of liberty, and stigma that come with criminal prosecution. They have to hide their practice, especially if and when they come in contact with the medical establishments that are charged with policing the boundaries of their profession (for example, when a client is transported to the hospital during delivery for an emergency).[94] For clients, this means that they risk this interruption in their care, that they too have to hide from family or friends who may feel uncomfortable with their decision, or potentially having to protect their care provider from prosecution or risk incriminating them. The whole endeavor comes with an added and unnecessary fear of external complications.[95]

In the twenty-two states where midwives face potential criminal prosecution just for practicing midwifery, the professional risk is high. This threat of prosecution guarantees that the profession and its pool of clients will be small and that it will be hard to attract new midwives to the field and expand the profession. This also means that midwives will be disenfranchised; when the law is your enemy instead of your ally it

[90] *Direct Entry Midwifery State-by-State Legal Status*, MIDWIVES ALLIANCE OF N. AM. (May 11, 2011), http://mana.org/pdfs/Statechart-05-11-11.pdf [hereinafter *Direct Entry Midwifery*].

[91] These states are: Alabama, Connecticut, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, West Virginia, District of Columbia and Puerto Rico. Georgia and Pennsylvania laws are in transition, and Wyoming legalized midwifery as of April 2010. *Certified Professional Midwives (CPMs) Legal Status By State*, *supra* note 89.

[92] *See Two midwives arrested on felony charges*, THE GOSHEN NEWS ((April 4, 2012)http://www.goshennews.com/local/x1451005078/Two-midwives-arrested-on-felony-charges (explaining that two CPMs were arrested for practicing midwifery in Indiana where non-nurse midwives are illegal).

[93] *See generally* Caitlin Slessor, *The Right to Choose Childbirth: Regulation of Midwifery in Iowa*, 8 J. GENDER RACE & JUST. 507 (2004); Jason M. Storck, *A State of Uncertainty: Ohio's Deficient Scheme of Midwifery Regulation in Historical and National Context*, 8 QUINNIPIAC HEALTH L.J. 89 (2004); Bruce Hoffman, The Cultural Power of the Law: The Criminalization, Organization, and Mobilization of Independent Midwifery (2004)(published Ph.D. dissertation, University of Washinton); Patricia G. Tjaden, *Midwifery in Colorado: A Case Study in the Politics of Professionalization*, 10 QUALITATIVE SOC. 29 (1987).

[94] In conversations with midwives who practiced under such conditions, and even those who practice in states where midwifery is legal, this may mean that the midwife has to leave her client at the hospital and cannot continue to support her through birth there. *See infra* pp. 22-24.

[95] Many people worry about "complications" during birth, but here the complications include the risk that their care provider will be criminally prosecuted.

becomes hard to advocate for yourself within the confines of the law.[96] The economic realities[97] reinforce this disenfranchisement; midwives who make a simple living are less likely to be able to pay for a lobbyist, lawyer, media campaign, or a settlement should they be found negligent. This lack of access to political and economic power contributes to the midwife becoming "'impossible even [to] mention.'"[98] While those that do practice and choose midwifery care under these circumstances are likely to be tenacious and devoted, the fact remains that criminalization of midwifery structurally limits who has access to this profession and kind of care.[99]

The risk of practice is different in those twenty-eight states where midwifery is regulated, but not by much.[100] The fact that home birth midwives in neighboring states may face criminal prosecution make midwives everywhere feel threatened.[101] The psychological impact on the profession and clients are similar, and therefore, midwifery, even in regulated states, remains structurally limited to a small population of both providers and clients. Plus, being able to practice legally doesn't protect midwives from the bias against midwifery that can exacerbate their risk of prosecution after a bad outcome.[102] For some midwives, professionalization is seen as a loss and their practice under the new law is actually more restricted than it was before (if less legally precarious).[103] Once regulated, the risk of practice depends on these factors, which vary from state to state: how easy it is to lose your practice, how much power the medical field has in the administrative/regulatory scheme, how enfranchised midwives are, and how safe consumers feel.

Legalization replaces criminalization with a system of professional censure. Instead of being vulnerable to criminal prosecution, midwives are now vulnerable to civil laws[104] and administrative regulations.[105] These

[96] *See* ROOKS, *supra* note 1, at 232 ("[a]lthough these laws began as efforts to license *lay* midwives, the requirements for licensure have become more arduous in some of these states over time.").

[97] *Infra* pp. 39-45.

[98] ROOKS, *supra* note 1, at 25.

[99] Not only are home birth midwives and clients in these states tenacious and devoted there are those who are philosophically opposed to regulation and committed to a sort of "off the grid" lifestyle. *See* ROOKS, *supra* note 1, at 230-31.

[100] *Id.* at 239 ("[m]any direct-entry midwives continue to prefer individual or local responsibility over national-level authority regarding midwivery."); *see also* Tjaden, *supra* note 88, at 29-30 (discussing difference in opinion between licensed midwives and lay midwives with regards to becoming allies in a national organization).

[101] *See* Hoffman, *supra* note 93, at 64 (explaining laws such as those that prohibit midwives from carrying medication and suturing make midwives feel threatened).

[102] *Stepped up sanctions for home birth in Delaware have expecting moms adjusting plans*, NEWSWORKS (December 13, 2013) (explaining Delaware law and it's impact on non-nurse midwives, including a midwife who couldn't get a permit and was then prosecuted after a bad outcome). http://www.newsworks.org/index.php/local/healthscience/62755-hunting-for-a-home-birth.

[103] ROOKS, *supra* note 1, at 239.

[104] *See generally* MAINSTREAMING MIDWIVES, *supra* note 4.

[105] *See generally id.* (note how the administrative structure overlaps with the professional structure here).

laws and regulations vary from state to state.[106] Midwives talk about states with "good" laws and "bad" laws.[107] Good laws are the ones that most closely match the national professional organization's standards of practice and where midwives feel generally empowered.[108] Bad laws are the ones that define the practice by external (usually medical) terms, force midwives to practice in ways that compromise their training and knowledge, and operate in disempowering contexts.[109]

The law of the jurisdiction is dictates how risky the practice of midwifery is. In addition, how the law is enacted is generally dependent upon the agency that oversees the profession. Unlike doctors who essentially run their own Boards of Medicine, most home birth midwives are regulated by other boards, such as the Board of Public Health, Nursing, or other general professions and occupations.[110] This could mean that someone unfamiliar with midwifery oversees the program and decides, for example, which complaints to pursue, and what kind of disciplinary action to take.[111] These agencies are impacted by the administrative structure described above, which already makes midwives invisible. Coupled with the fact that very few lawyers are experienced in defending home birth midwives, this means midwives will struggle to find good advocates during investigations.[112]

Finally, when it comes to changing the law, midwives struggle to pay for professional lobbying, and have a very small constituency (most home birth midwives attend less than 1% of all births in a State), and the nature of the profession itself makes organizing hard.[113] Midwives are often at births for many hours at a time, at all times of the day and night, and they often travel long distances to get to their clients.[114] In contrast, the nurses

[106] *See Legal Status of US Midwives*, *supra* note 14.

[107] *See* Kathi Valeii, *Oppressive Midwifery Laws Hurt Women and Babies*, BIRTH ANARCHY (May 22, 2013), http://birthanarchy.com/oppressive-midwifery-laws-hurt-women-babies.

[108] *See* NARM, *supra* note 12.

[109] *See State by State*, MIDWIVES ALLIANCE OF N. AM., http://www.mana.org/about-midwives/state-by-state (last visited Apr. 9, 2014) (discussing the laws in each state).

[110] *See* Alyson Reed & Joyce E. Roberts, *State Regulation of Midwives: Issues and Options*, 45 J. MIDWIFERY & WOMEN'S HEALTH, No.2, 2000, at 135-36.

[111] In Colorado, the Department of Regulatory Agencies oversees the midwifery program. Based on records from the 2005-2006 fiscal year, the percent of complaints received and handled by the midwifery program, per active licensee was 32% - or three of every 10 registered midwives had a complaint. This rate far exceeds the rate of all other registered occupations. Dep't. Reg. Agencies, ANNUAL REPORT: DEPARTMENT OF REGULATOR AGENCIES, DIVISIONS OF REGISTRATIONS, FY2006-2007 (2007).

[112] ELLEN A. BUMANN ET AL., FROM CALLING TO COURTROOM: A SURVIVAL GUIDE FOR MIDWIVES (2004), *available at* http://www.fromcallingtocourtroom.net/defaultchap4.htm.

[113] For birth data see Joyce Martin et. al., *Births: Final Data for 2006*, 57 NAT'L. VITAL STATISTICS REP. 1, 16 (2009) (stating that less than one percent of births were out-of-hospital, and of those 64 percent were at home).

[114] *See generally* ROOKS, *supra* note 1; MAINSTREAMING MIDWIVES, *supra* note 4.

and doctors who often oppose midwifery legislation have far more resources, better access, and larger constituencies.[115]

Even in states where midwifery is legal, the regulatory scheme and professional climate vary greatly.[116] The more medicine is central to the regulatory scheme, the riskier it will be for home birth midwives because their profession does not fit well within the bounds of medicine. When midwives are defined by medicine in their scope of practice and in their standard of care, they are fundamentally at risk from prosecution and negligence liability, because they're being defined by something they're not.[117] In some states the situation is so hostile it is not much different than in states where midwifery is criminalized, and in others it can even be collegial.[118] The point is that the status of the profession and its viability is deeply impacted by these administrative and professional structures.

Doctors are also impacted by this regulatory scheme, of course, but they do not often understand how their regulatory scheme is different.[119] They are also given reasons to police the conduct of midwives in order to keep medicine at the top of the hierarchy; in 2005 the American Medical Association adopted resolution 814 for just this purpose.[120] That resolution seeks 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. . . .[121]

[115] The American College of Obstetricians and Gynecologists claim more than 55,000 members. *Leadership & Governance*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, http://www.acog.org/About_ACOG/Leadership_and_Governance (last visited Apr. 14, 2014). In contrast the Midwives Alliance of North American notes there are only about 15,000 midwives in the US. ACOG spent over 1.5 million dollars on lobbying in 2013. *Health Professionals*, OPENSECRETS.ORG, http://www.opensecrets.org/lobby/indusclient.php?id=H01&year=2013 (last visited Apr. 14, 2014). In contrast, the nurse-midwives spent only $60,000, and none of the other midwifery organizations were listed as having spent any money lobbying. *Id.* This fact also helps account for the extent to which midwifery laws reflect the language and priorities of the medical profession less than they reflect the language and priorities of midwives.

[116] *See Direct Entry Midwifery*, *supra* note 90.

[117] *See infra* notes 135-40 and accompanying text.

[118] *See, e.g.*, Slessor, *supra* note 93, at 509.

[119] *See* Starr, supra note 47, at 24-29.

[120] Pushgirl Friday, *Statement of the Big Push for Midwives Campaign on the AMA Scope of Practice Partnership*, THE BIG PUSH FOR MIDWIVES (July 15, 2013), http://pushformidwives.org/2013/07/15/big-push-statement-on-ama-sopp/.

[121] *Id.*; *see also* Shikha Dalmia, *The Evil-Mongering Of The American Medical Association*, FORBES (August 26, 2009, 12:00 AM), http://www.forbes.com/2009/08/25/american-medical-association-opinions-columnists-shikha-dalmia.html.

This statement is a perfect example of how the medical system's regulatory scheme creates incentives for doctors to police midwives.[122] Leaders within the profession are tasked with keeping midwifery on the margins.[123] The more medicalized a state law already is, or the more disenfranchised midwives in a certain state are, the more vulnerable they are to this explicit threat. Regardless of whether this is right or wrong, the fact of the matter is that it impacts the viability of the profession of midwives and the access clients have to their care.

Aside from how safe midwives feel, their ability to practice is also impacted by how safe consumers feel. In a climate where potential consumers have the impression that medical professionals deride midwifery, consumer confidence will be diminished. Consumers will respond to how valued and valid the profession is, in terms of public and medical opinion.[124] This is impacted by the information and experience that people have, but it is also impacted by structural factors like how integrated the profession is into other systems, like insurance.[125] Most insurance plans will not cover home birth midwives.[126] This reinforces the misperception that home birth midwifery is risky in a way that structurally limits the viability of the profession.

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[122] *Board Information*, COLORADO.GOV, http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251630469213 (last visited May 20, 2014). Unlike the midwives in Colorado, for example, the doctor's complaints are reviewed by a panel of doctors and a couple community member who determine whether their actions violated the medical practice act. DEPARTMENT OF REGULATORY AGENCIES, DIVISION OF PROFESSIONS AND OCCUPATIONS, FILE A COMPLAINT (2014), *available at* cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/D)RA/1251632504829; DEPARTMENT OF REGULATORY AGENCIES, DIVISION OF PROFESSIONS AND OCCUPATIONS, BOARD INFORMAION (2014), *available at* http://cdn.colorado.gov/cs/Satellite/DORA-Reg/CBON/DORA/1251632243741. This type of professional oversight creates incentives for doctors to police each other and themselves in accordance with standards like resolution 814. In addition, doctors rely on access to practice in hospitals where the medical staff are similarly self-governing. Finally, there are also federal incentives to tow the line, under the medicare and medicaid programs. *See* Michael F. Schaff, *Representing Physicians*, FUNDAMENTALS OF HEALTH LAW 311 (2008). In addition, there is a long history of doctors policing midwives with the goal of eliminating the profession. *See* ROOKS, *supra* note 1, at 21-26.

[123] *See* PushGirl Friday, *supra* note 120.

[124] See Huang, Xiaoyan, *Why are health care consumers not making smart decisions?*, KEVINMD, (October 19, 2013) Available at: http://www.kevinmd.com/blog/2013/10/health-care-consumers-making-smart decisions.html (explaining the complexity of consumer decision making in health care). See also, *Behavioral Economics Holds Potential To Deliver Better Results For Patients, Insurers, And Employers*, 32 Health Affairs 7, 1244-1250 (July 2013); Jay Katz, THE SILENT WORLD OF DOCTOR AND PATIENT, Johns Hopkins University Press (2002); and Grace C. Grinager, *The Political Economy of Birth Choice: Mothers' Experiences Seeking Homebirth Care in a Felonious State*, Thesis presented on March 8, 2011, Oregon State University.

[125] Michelle Andrews, *Health Law Provides No Guarantees of Access to Midwives, Birthing Centers*, KAISER HEALTH NEWS, Mar. 4, 2014, http://www.kaiserhealthnews.org/Stories/2014/march/04/michelle-andrews-health-law-provides-no-guarantees-of-access-to-midwives.aspx?referrer=search.

[126] *Id.*

THE LIABILITY STRUCTURE: WHO IS RESPONSIBLE

Historically, the doctrine of common callings established a general duty of care for individuals in certain burgeoning professions, so that each professional was expected to apply their specialized knowledge with ordinary care and diligence.[127] Eventually, this concept expanded to become what we now know as negligence.[128] This doctrine holds that if a professional fails to properly apply their standard of care, they can be held responsible for the consequences.[129] In response to this special liability, the insurance industry provides products for professionals that will offset costs associated with a negligence suit.[130] While carrying professional liability insurance is rarely required by law it is often necessary in order to access federal and state reimbursements and to practice in certain facilities, like hospitals.[131] Therefore, midwives are impacted by the structure of liability in two ways: the standard of care and the professional liability market.

The standard of care is the legal basis for evaluating the negligence of a professional.[132] Case history suggests that there is confusion about the proper standard of care to apply to midwives in a negligence suit.[133] Cases in the 1980s and 1990s responded to changes in the legal and professional status of midwives in a variety of ways: some courts made midwifery legal by judicial interpretation;[134] other courts recognized the expanding role of nurses;[135] still others continued to define midwifery as the practice of medicine and criminally sanction certain midwives.[136]

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[127] Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1202-05 (1992).

[128] *Id.* at 1202 ("That fourteenth century common law should have attached a general duty of care and prudence to the 'common calling' but not to the whole of human activities may reflect the relatively unevolved civic values prevailing at that time.").

[129] *Id.*

[130] Charles M. Key, *Maintaining Professional Liability Insurance Coverage: Basics for the Careful Shopper*, 12 HEALTH L. 23, 23 (1999).

[131] *FAQ*, MIDWIFERY EDUC. ACCREDITATION COUNCIL, http://www.meacschools.org/education-faq/ (last visited Mar. 11, 2014) ("[m]ost direct-entry midwives are not covered by professional liability insurance, unless it is required for practice in their State or for participation in healthcare plans.").

[132] H.H. Henry, *Necessity of Expert Evidence to Support an Action for Malpractice Against a Physician or Surgeon*, 81 A.L.R. 2d 597 (1962).

[133] *See* Leggett v. Tenn. Bd. of Nursing, 612 S.W.2d 476, 477 (Tenn. Ct. App. 1980).

[134] *Leggett*, 612 S.W.2d at 480-81 (holding that plaintiff was not acting in her capacity as a nurse when performing deliveries of children and therefore, nurse regulation 32 was inapplicable to plaintiff); State Bd. of Nursing v. Ruebke, 913 P.2d 142, 151, 156-58 (Kan. 1996) (holding that the Attorney General's decision about the illegality of midwifery was not intended to be illegal within the meaning of Kansas' regulatory scheme).

[135] Bleiler v. Bodnar, 479 N.E.2d 230, 234 (1985) (stating that the role of nurses has expanded to include more complex areas of health); Bellegie v. Texas Bd. of Nurse Examiners, 685 S.W. 2d 431, 434 (Tex. App. 1985) (making declaratory judgment for nurse midwife accused of practicing medicine without a license stating that nurse had "not enlarged the scope of practice" beyond the statute); Louisiana State Bd. Med. Soc. v. Louisiana State Bd. of Nursing, 493 So.2d 581, 589 (La. 1986) (refusing judicial review since nurse practitioner statute that Board of Medicine challenged had been on the books five years without challenge); Cook v. Workers' Compensation Dep't, 758 P.2d 854 (Or.

The standard of care that is applied in a negligence action is an important way that the profession is defined. Midwifery is different from obstetrics; it's not mini-obstetrics, or "obstetrics light;" midwifery is to obstetrics more like acupuncture is to surgery, a very different philosophy of health and healing. Each profession is distinct. Three organizations collectively articulate national standards for the practice of home birth midwifery.[137] The North American Registry of Midwives (NARM) deals with certification,[138] The Midwifery Education Accreditation Council (MEAC) handles accreditation,[139] and the National Association of Certified Professional Midwives (NACPM) sets professional standards.[140] However, these organizations do not necessarily define the midwifery standard of care under the law. It takes a long time for the law to develop, and the law surrounding midwifery negligence is still relatively new.[141] Nonetheless, the cases against certified nurse midwives are illustrative.

In these cases, the standards of care applied to nurse-midwives have included OB/GYN standards of care, nurse standards of care, and nurse-midwife standards of care.[142] We can assume that a home birth midwife would have an even harder time being measured against the appropriate

1988) (Nurse practitioners can be designated "attending physicians" within the meaning of the worker's comp statute). *See also* Broussard v. Sears Roebuck & Co., 568 S.2d 225 (La. 1990) (interpreting malpractice statute and include nurse practitioners); Sullivan v. Edward Hospital, 806 N.E.2d 645 (Ill. 2004) (stating that a physician cannot testify as an expert as to a nurse's standard of care).

[136] *See* Mo. State Bd. Of Registration for Healing Arts v. Southworth, 704 S.W.2d 219 (Mo. 1986) (en banc) (holding that engaging in the practice of midwifery without being a registered physician was unlawful); Smith v. Indiana *ex rel*. Med. Licensing Bd. Of Ind., 459 N.E.2d 401 (1984) (stating that midwifery is contained within the definition of medicine requiring a license to practice and that the defendant was therefore guilty of practicing medicine without a license); People v. Odam, 82 Cal. Rptr. 2d 184 (1999)(finding the unlicensed midwife defefendant guilty of practicing medicine without a license despite midwifery regulation that might have been used to regulate the practice of midwifery – case was remanded and put on hold pending another action*) superseded by In re* Odam, 977 P.2d 65 (Cal. 1999). *See also* Michelle Dynes, *Midwife Pleads Guilty in Death*, WYOMINGNEWS.COM, http://www.wyomingnews.com/articles/2007/11/17/local_news_updates/20local_11-17-07.txt#.UOM37F2ayUK.

[137] *See What is a CPM*, NARM, http://narm.org (last visited Apr. 8, 2014); MIDWIFERY EDUC. ACCREDITATION COUNCIL, http://meacshools.org (last visited Apr. 8, 2014); NAT'L ASS'N OF CERTIFIED PROF'L MIDWIVES, http://nacpm.org (last visited Apr. 8, 2014).

[138] NARM, *supra* note 136.

[139] MIDWIFERY EDUC. ACCREDITATION COUNCIL, *supra* note 136.

[140] *See Certified Professional Midwives in the United States: An Issue Brief*, MIDWIVES ALLIANCE OF N. AM. (June 2008), http://mana.org/pdfs/CPMIssueBrief.pdf.

[141] *See Unlicensed Midwife, 71, Who was Responsible for Baby's Death in Michigan Moved to Utah Where she Cause Another Newborn to Die*, DAILY MAIL (Sept. 23, 2013) http://www.dailymail.co.uk/news/article-2430001/Valerie-El-Halta-71-charged-negligent-homicide-unlicensed-midwife.html; Schmidt v. Ramsey, No. 8:13CV143, 2013 WL 6178533 (D. Neb. Nov. 25, 2013).

[142] Miller v. Phillips, 959 P.2d 1247, 1248 (Alaska 1998); Ali v. Cmty. Health Care Plan, Inc., 801 A.2d 775, 776 (Conn. 2002); McElhaney v. Harper-Hutzel Hosp., 711 N.W.2d 795, 799 (Mich. Ct. App. 2006).

standard in a suit for negligence.[143] Three cases demonstrate the range of contortions used to address the nurse-midwife's standard of care today.[144] The first case uses a hybrid model, the second defines a nurse-midwife as one who practices obstetrics and uses the OB/GYN standard accordingly, and the third case defines the nurse-midwife as a nurse and applies a distinct CNM standard of care.[145]

In *Miller v. Phillips*, a nurse-midwife was responsible for the prenatal care and delivery of a baby born with "Erb's palsy."[146] Hospital policy required that nurse-midwives be assigned an OB/GYN for supervision.[147] The supervising doctor in this case never met the patient but reviewed her chart, authorized continued care by the CNM, consulted with the CNM during delivery and was the admitting physician.[148] Pregnancy and labor progressed normally until a few minutes before birth when the baby's shoulder became stuck behind his mother's pubic bone (shoulder dystocia).[149] The CNM applied "traction" on the baby's head to dislodge him, causing injury to the cervical spine, resulting in the palsy.[150]

This case is an example of a hybrid standard of care resulting from the testimony of an OB/GYN, a CNM, an "expert advisory panel," the CNM herself, and the supervising OB/GYN.[151] All of these experts unanimously testified that the CNM's use of traction fell within the requisite standard of care.[152] At issue on appeal was whether the supervising obstetrician's testimony was proper since he was not listed as an expert witness, but testified as a treating doctor.[153] However, since his "treatment" consisted of supervision, his testimony was necessary to assess the CNM's standard of care.[154] The court referred to him as a "hybrid" witness and found his testimony proper, particularly because his testimony was not found to have caused unfair surprise.[155]

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[143] Other issues arise when there are student midwives or people with dual licenses involved. In a New York case a judge denied a motion to dismiss a medical malpractice suit for a student midwife who was present at the birth of a stillborn baby. Lacy v. My Midwife, P.C., 873 N.Y.S.2d 234 (N.Y. Sup. Ct. 2008). Note: CPMs cannot legally practice in New York, which requires the CM certificate instead. As a result, most of the midwives who do home births in New York are Certified Nurse Midwives, as was the case here. *See License Requirements*, NYSED.GOV (Sept. 27, 2013), www.op.nysed.gov/prof/midwife/midwifelic.htm.

[144] *See Miller*, 959 P.2d at 1249; *Ali*, 801 A.2d at 776; *McElhaney*, 711 N.W.2d at 799.

[145] *Miller*, 959 P.2d at 1250; *Ali*, 801 A.2d at 776; McElhaney, 711 N.W.2d at 801.

[146] *Miller*, 959 P.2d at 1249.

[147] *Id.* at 1248.

[148] *Id.* at 1248-49.

[149] *Id.* at 1249.

[150] *Id.*

[151] *Miller*, 959 P.2d at 1249-50.

[152] *Id.* at 1249.

[153] *Id.* at 1250.

[154] *Id.* at 1250-51.

[155] *Id.* at 1250 (upholding a ruling in favor of the CNM).

This case suggests that there is a unique CNM standard of care, and that the standard can be ascertained by multiple experts with different credentials. As in this case, a CNM can testify as an expert as to her own standard, and that supervising physicians can be hybrid witnesses. While the unanimous testimony of all of these experts against the one physician called by the plaintiff presented a powerful case for the CNM, it is possible to see what kind of confusion could ensue with less agreement among the experts.[156]

In *Ali v. Community Health Care Plan*, the plaintiff was treated by the medical staff of an HMO, which included nurse-midwives.[157] After having amniocentesis, the plaintiff experienced vaginal discharge and called the HMO to report it.[158] The plaintiff conferred with a nurse-midwife who, based on the plaintiff's description, did not think the discharge was amniotic fluid, thus, did not require an exam.[159] Twelve days later the plaintiff experienced vaginal bleeding and called the HMO, this time conferring with a physician who recommended she be seen at the nearest hospital.[160] There, the medical staff found she had suffered severe loss of amniotic fluid and recommended delivery of the baby who, at twenty-one weeks, died shortly thereafter.[161]

Here, the standard of care originated with the state statute, which defines it as "that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."[162] Thus, the court determined that the standard of care should be that of "a reasonably prudent nurse-midwives engaged in the practice of obstetrics and gynecology."[163]

The plaintiff argued that this resulted in a lower standard of care, but the court was unconvinced for two reasons.[164] First, both parties agreed that if the discharge reported had been amniotic fluid the standard of care required the patient be examined in person.[165] Second, the plaintiff's expert witness, a board certified OB/GYN was asked during cross-examination whether a CNM was a "practitioner of obstetrics and gynecology," and replied, "[a]bsolutely."[166] This answer certainly confuses the distinction between these professions. Despite the statutory definition of a CNM as one who provides management of maternity care

[156] *See id.* at 1250-51.
[157] Ali v. Cmty. Health Care Plan, Inc., 801 A.2d 775, 776 (Conn. 2002).
[158] *Id.* at 776-77.
[159] *Id.* at 777.
[160] *Id.*
[161] *Id.*
[162] *Id.* at 780.
[163] *Id.* at 777-78.
[164] *Id.* at 779.
[165] *Id.* at 781-82.
[166] *Id.* at 781, n.9.

"within a health care team, directed by a qualified obstetrician-gynecologist,"[167] in this case, it is as if the nurse-midwife was able to practice obstetrics directly.

The court did not directly address this problem. The question of whether a non-physician health care provider under the supervision of an MD should be held to a lower standard of care, and whether a nurse-midwife could be practicing something other than obstetrics remain unanswered. This case does suggest that a nurse-midwife is an independent health care provider (in contrast to the statute), that a nurse-midwife practices obstetrics and gynecology, and that a nurse-midwife is not necessary to determine a CNM standard of care.[168] Here, the fact that the plaintiff's OB/GYN and the defendant CNM agreed as to the standard of care, was significant for the court in this case.[169]

In *McElhaney v. Harper-Hutzel Hospital,* the plaintiff sued the hospital for the negligent actions of its "'doctors, nurses, a nursing midwife, and residents,'" during childbirth, resulting in mental retardation.[170] Michigan law requires an affidavit of merit, written by someone reasonably believed to qualify as an expert witness that delineates the standard of care, be presented to the court in medical malpractice cases.[171]

Here, the affidavit presented was written by a physician.[172] The defendants were granted summary judgment since the expert was not qualified to offer testimony as to the nurse-midwife's standard of care.[173] The reviewing court agreed that while it was reasonable to believe the physician could testify as to the standard of Harper-Hutzel's doctors, it failed to establish a genuine issue of material fact as to the nurse-midwife's liability since the experts were not qualified to evaluate a CNM standard of care.[174] In this case, physicians and nurse-midwives are licensed to practice under two different sections of the Public Health Code, and the statutory requirements of an expert witness include practice or instruction in the "'same health profession'" as the defendant, with stipulations for differences between general practitioners and specialists.[175] Since the terms "specialist" and "general practitioner" are not defined in the statute the court looked to case law where those terms were aligned with the practice of medicine.[176] The law defined nurse-midwives as nurses with specialty certification in nurse midwifery.[177] Since the expert witnesses in

[167] *Id.* at 782, n.12.
[168] *Id.* at 782.
[169] *Id.* at 781-82.
[170] McElhaney v. Harper-Hutzel Hosp., 711 N.W.2d 795, 799 (Mich. Ct. App. 2006).
[171] MICH. COMP. LAWS ANN. § 600.2912e (West 2013).
[172] *McElhaney*, 711 N.W.2d at 799.
[173] *Id.* at 800-01.
[174] *Id.*
[175] *Id.* at 800.
[176] *Id.* at 798-99.
[177] MICH. COMP. LAWS ANN. § 333.17210 (West 2013).

McElhaney were physicians, they were not qualified to offer evidence of the standard of care for nurses.[178]

The court stated that in this case "[t]he parties agree[d] that nurse midwives do not practice medicine."[179] Instead of giving physicians the widest scope of expertise encompassing all "health professions," this court constrained their expertise more narrowly.[180] This case suggests that nurse-midwifery is an independent health profession, with an independent standard of care, and that CNM's are required to testify as experts to the CNM standard of care.[181]

The conclusions in *Ali* and *McElhaney* are contradictory. In *Ali* the distinction between medicine and nursing is blurred; a nurse-midwife can be held to the same standards as a practitioner of obstetrics and gynecology.[182] That result would be impossible in *McElhaney*, where a nurse-midwife was practicing nursing, even when engaged in obstetric care.[183] The result in *Miller* attempts to avoid these contradictions by having multiple health care providers, doctors and nurse midwives alike, testify as to the CNM standard of care.[184] The point is that the standard of care varies widely for midwives, unlike other professionals, as does the standard for the appropriate expert to give testimony. In order for midwifery to be "possible" it has to be recognized as a distinct profession, with a distinct standard of care.[185] Lacking a clear definition, midwives are seen as outsiders, not only to the medical profession who attend 99% of the births in this country, but to those millions of citizens who experience childbirth in the medical context.[186] "The medical services rendered in this coextensive area are essentially the same. The difference is the model of care delivery."[187]

The other way that home birth midwives are excluded from the liability structure is through the professional liability market.[188] Some state regulations require that midwives carry professional liability insurance, and

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[178] *McElhaney*, 711 N.W.2d at 801.

[179] *Id.* at 798.

[180] *Id.* at 797-98.

[181] *Id.* at 798.

[182] *Ali*, 261 801 A.2d at 782.

[183] *McElhaney*, 711 N.W.2d at 800.

[184] *Miller*, 959 P.2d at 1249-51.

[185] *See id.*

[186] *See Direct Entry Midwifery*, *supra* note 90 (identifying states that do not explicitly prohibit, but do not legally define a midwife).

[187] Susan E. Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX 325, 341 (1992).

[188] CAROL SAKALA, ET AL., MATERNITY CARE AND LIABILITY: PRESSING PROBLEMS, SUBSTANTIVE SOLUTIONS, CHILDBIRTH CONNECTION (New York: Childbirth Connection 2013), *available at* http://transform.childbirthconnection.org/wp-content/uploads/2013/02/Maternity-Care-and-Liability.pdf; *see also* Dennis Domrzalski, *Midwives Facing Malpractice Insurance Crises*, ALBUQUERQUE BUS. FIRST (Feb. 3, 2005, 4:55PM), http://www.bizjournals.com/albuquerque/stories/2005/02/07/story5.html?page2.

some health insurance companies require that the care providers in the network carry insurance (including some state Medicaid programs).[189] However, in many places, professional liability insurance is not available to home birth midwives.[190] And there are only a few companies that offer such coverage.[191] Even when it is offered it can be inconsistent, unstable, and incomplete.[192] One birth center in New Mexico had been practicing for twenty-three years and had never been sued, but still faced loss of coverage when the insurance company withdrew from the market.[193]

As a result, many home birth midwives do not carry professional liability insurance.[194] This is another example of how and why structural factors limit the practice of home birth midwifery; without insurance a single incident could put uncovered midwives out of business.[195] Not having liability insurance has worked well for many midwives within the context of a very small volume of clients, but if the volume were to increase this might not work out so well.[196] The balance between professional liability and access to care is an issue regardless of provider-type.[197] Nonetheless, there are gaps in knowledge about how liability impacts home birth midwives.[198] It is generally agreed that home birth midwives cannot afford insurance, and when they do purchase insurance, it is often expensive.[199] Midwives are at risk of being dropped from coverage, creating more hassles that ultimately lead midwives to advocate against insurance and place them in a "neither here nor there" state of

[189] SAKALA ET AL., *supra* note 188, at 16-18; Domrzalski, *supra* note 188.

[190] Domrzalski, *supra* note 188.

[191] *See Home: Welcome to the Midwife Plan*, THE MIDWIFE PLAN, http://www.themidwifeplan.com/about/ (offering a general liability policy designed for home birth midwives); *see also* E-mail from Susan Jenkins, esq., Counsel, The Midwife Plan to Indra Lusero, Author (Apr. 27, 2010, 12:10:15 MST & May 10, 2010 6:34:46 MDT) (on file with author) [hereinafter E-mail from Susan Jenkins] (The Midwife Plan is going to be offering liability insurance for midwives starting in June or July of 2010. It will be a non-profit, mutual, risk retention company with coverage limits of $750,000 and $3 million. They will not offer coverage in every state, nor do any of the other two carriers).

[192] *See* E-mail from Susan Jenkins, *supra* note 191.

[193] Domrzalski, *supra* note 188.

[194] *FAQ For Students: Do Midwives Carry Professional Liability Insurance*, MIDWIFERY EDUC. ACCREDITATION COUNCIL, http://www.meacschools.org/prospective_students.php#Answer24 (last visited May 20, 2014).

[195] *See* Xia Xu et al., *Malpractice Liability Burden in Midwifery: a Survey of Michigan Certified Nurse-Midwives*, 53 J. MIDWIFERY & WOMEN'S HEALTH 19, 19 (2008) (discussing the impact of liability insurance on nurse midwives).

[196] *See id.* at 23.

[197] *See* MICHELLE MELLO, ROBERT WOOD JOHNSON FOUNDATION, Understanding Medical Malpractice Insurance: A Primer(2006); Sarah D. Cohn, *Professional Liability Insurance and Nurse-Midwifery Practice, Med. Prof. Liability and the Delivery of Obstetrical Care: Volume II, An Interdisciplinary R.*, 104-112 (1989); Arnold Relman, Medical Professional Liability and the Relations Between Doctors and Their Patients, in Med. Prof. Liability and the Delivery of Obstetrical Care: Vol. II, an Interdisciplinary R., 97 (Inst. of Med. Ed., 1989).

[198] SAKALA ET AL., *supra* note 188, at 118.

[199] *See* SAKALA ET AL., *supra* note 188, at 16-18.

affairs.[200] Meanwhile, this impacts whether health insurance will cover home birth midwifery care, which keeps the pool of potential clients small, which reinforces the perception that midwives can get away without carrying coverage.[201]

This increases the degree to which medical professionals distrust home birth midwives, fearing that they will be the "deep pockets" responsible for midwifery failures.[202] Of course, part of why doctors fear this is because of their own struggles with insurance.[203] Doctors know how insurance underwriting can actually dictate the scope of practice and how they provide care.[204] Many find insurance and medical malpractice litigation to blame for the system of "perverse incentives" in maternity care,[205]and yet research does not support the contention that high premiums or payouts have that much impact.[206]

For midwifery, the risk of insurance dictating practice is a reality. Most actuarial data does not include good information about home birth, partly because that information is not collected by the federal government, nor is it entered into databases upon which much actuarial data is based.[207] This is another part of the self-perpetuating system that diminishes the viability of home birth midwifery. The data is not available because the practice is small, the practice is small because it's viewed as risky; the lack of data makes the practice seem risky and keeps the practice small. It's a loop of bad information leading to bad results.[208]

OTHER STRUCTURES

In addition to the administrative, professional and liability structures there are several other ways home birth midwifery becomes impossible to mention, which I will touch on briefly. These include legal theories and economics.

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[200] *Id.* at 18.

[201] *Id.*

[202] E-mail from Susan Jenkins, *supra* note 191.

[203] SAKALA ET AL., *supra* note 188, at 19.

[204] *Id.*

[205] CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 5 (2008), *available at* http://childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf.

[206] *See* Domrzalksi, *supra* note 188.

[207] *See* SAKALA & CORRY, *supra* note 205, at 16.

[208] It is beyond the scope of this paper to prove the safety of home birth, but suffice it to say, there are ample studies to this end. *See generally* Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. OF MIDWIFERY & WOMEN'S HEALTH 17 (2014)(examining the results of planned home births from 2004 to 2009 in the U.S.); *see also* Sara Swathi Vedam et al., *Home Birth: An Annotated Guide to the Literature* (2012), http://www.mana.org/research/homebirth-safety (last updated Sep. 2012)("assess[ing] the quality of the available evidence on planned home birth[s]").

Legal Theories

The problematic legal theories flow from the State's interest in protecting potential life. The state asserts this interest to the detriment of midwifery by limiting the right to the birth attendant of one's choice, limiting advanced directives for pregnant women, limiting the right to refuse certain interventions during pregnancy, using criminal endangerment and neglect laws to limit birth choices, and other scenarios that make mother and child adversaries.[209]

The right of people to determine how or where they give birth is not yet recognized constitutionally, although rights that could lead to recognition of this principle certainly exist.[210] For the time being this means that as a matter of statutory and regulatory law, but constitutional law as well, the State may constrain the practice of midwifery.[211]

In Colorado, for example, midwives brought a constitutional challenge on behalf of pregnant women alleging that the State's prohibition on midwifery (this was before midwifery in Colorado was regulated) violated the privacy right of pregnant women to decide where to give birth.[212] The Court determined that "the state may, out of its interest in protecting the health of the mother and her child, proscribe the unlicensed practice of midwifery without violating the privacy right of the pregnant woman."[213] Although midwifery eventually became regulated, this law proscribing the practice remains on the books and the reasoning has been used in other jurisdictions.[214]

The same reasoning extends to other scenarios impacting pregnant people. In many states, the state has the power to override the advance directives of people who are pregnant forcing them to stay on life support or have life saving measures taken against their express wishes.[215] And the Eleventh Circuit has found that forcing a woman to undergo a cesarean section against her will is not a violation of her due process rights.[216] Some jurisdictions have applied criminal and civil child abuse statutes against pregnant women for their actions during pregnancy.[217] Taken together

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[209] Paltrow, *supra* note 3, at 299; Ehrenreich, *supra* note 5, at 496; Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 Colu. J. Gender & L. 85, 94 (1997) (explaining that most states have living will restrictions for pregnant women).

[210] *See* Supra note 3, Rebecca Spence, Abandoning Women to Their Rights: What Happens When Feminist Jurisprudence Ignores Birthing Rights, 19 Cardozo J. of L. and Gen. 1 (2012) for a more thorough discussion of these rights.

[211] *See Lange-Kessler*, 109 F.3d at 140.

[212] People v. Rosburg, 805 P.2d 432 (Colo. 1991).

[213] *Id.* at 437.

[214] *See* Sammon v. N. J. Bd. Of Med. Exam'rs, 66 F.3d 639 (3d Cir. 1995*); see also Lange-Kessler*, 109 F.3d at 139.

[215] Taylor, *supra* note 203 (explaining that most states have living will restrictions for pregnant women).

[216] *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp.2d 1247 (1999)*.

[217] *Paltrow*, *supra* note 3, at 320-22.

these legal theories create an additional and substantial structural limitation on the profession of midwifery.

Economic Structures

Maternity care in the United States is big business. Over four million babies are born a year, and the vast majority are born in the hospital, making childbirth the number one reason for hospitalization in the country.[218] Hospitalization is not cheap: hospital charges for laboring women and newborns total nearly eighty-billion dollars a year.[219] Hospitalization is procedure intensive (cesarean sections are the most common operating room procedure and it is usually accompanied by other procedures); for those in the childbearing years, almost half of all hospital procedures performed are obstetric.[220] What's more, even when the birth in a hospital is vaginal and uncomplicated, the charges are higher than for a similar birth in a free-standing birth center: $7,000 for vaginal birth in a hospital versus $1,600 for vaginal birth in a freestanding birth center.[221] Maternity care is also one of the top reasons for out-patient visits, ranking fourth overall.[222]

Out-of-hospital births, which account for less than one percent of all births, are increasing (after having been the norm a century ago), and include births in freestanding birth centers,[223] at home, and other unspecified locations.[224] Of these out-of-hospital births, about 64.7 percent are at home, and 28 percent are in a birth center.[225] Fees for home birth midwives vary by region, but average about $2,300.[226] I paid a home birth midwife about $2,500 out of pocket in 2003. This included nine months of prenatal appointments that lasted an hour each, several post-postpartum check ups, full-time hands on care for about 12 hours of birth, with an

[218] SAKALA & CORRY, *supra* note 205, at 1-2 (when combining care for women and newborns).

[219] SAKALA & CORRY, *supra* note 205, at 10-11 (figures are from 2005).

[220] *Id.* at 11.

[221] SAKALA & CORRY, *supra* note 205, at 12-13.

[222] SAKALA & CORRY, *supra* note 205, at 2, 10.

[223] *See generally Birth Centers: Alternatives to Hospitials*, BABYCENTER.COM, www.babycenter.com/0_birth-centers-alternatives-to-hospitals_2007.bc (last visited Apr. 14, 2014). A freestanding birth center is an independent facility and is not connected to or typically affiliated with a hospital. *See Birth Center*, AMERICANPREGANNCY.ORG, americanpregnancy.org/abornbirth/birthingcenter.html (last updated Jan. 2013). These birth centers are often owned and operated by certified nurse midwives, and are in a homelike settings. It is beyond the scope of this article to discuss the many (and overlapping, but unique) challenges faced by birth centers.

[224] Marian F. MacDorman et. al., *Trends and Characteristics of Home and Other Out-of-Hospital Births in the United States, 1990-2006*, 58 NAT'L VITAL STATISTICS REP. 11, 2 (2010) (amounting to about 38,500 out-of-hospital births in 2006).

[225] *Id.* at 2.

[226] David A. Anderson, *Notes on the Economics of Out-of-Hospital Maternity Care*, MISSISSIPPI FRIENDS OF MIDWIVES, (May 23, 2011, 2:40 PM), www.facebook.com/notes/mississippi-friends-of-midwives/notes-on-the-economics-of-out-of-hospital-maternity-care/214329595256537.

additional two midwives present toward the end (prenatal care is generally not included in the cost of a hospital birth).

The economic players in the maternity care industry include insurance companies, hospitals, doctors, anesthesiologists, other medical staff, hospital equipment manufacturers and distributors (not to mention billing/accounting/coding people, lawyers, and administrative support staff).[227] In the hospital, nurses primarily care for people during labor; obstetricians are often being consulted with but do not arrive until the last hour or so of birth.[228] Just over 90% of births are attended by physicians, with certified nurse-midwives accounting for most of the rest.[229] In cases where an obstetrician is not attending, there may be a family practice doctor, a certified-nurse-midwife or a physician's assistant.[230]

Lots of money changes hands during pregnancy and birth, most of it paid by Medicaid and private insurance (together they are the payers for about ninety-three percent of hospital births), and for a long list of interventions involving an extensive medical staff.[231] Payments are significantly less than charges, but payment information is often not available.[232] There is a large differential between payments for cesarean sections versus vaginal births, with cesareans being on average $3000 more than vaginal births.[233] There is also a differential between payments to certified-nurse midwives versus obstetricians for the same kind of birth, with midwives sometimes receiving thirty-five percent less than doctors.[234] Home birth midwives are rarely reimbursed by federal or private programs; when they are, there is still a rate differential.[235]

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[227] *See* Blum, *supra* note 49, at 470-75, 492.

[228] ROOKS, *supra* note 1, at 104.

[229] Joyce A. Martin et al., *Births: Final Data for 2006*, 57 NAT'L VITAL STAT. REP. 7, 16 (2009).

[230] ROOKS, *supra* note 1, at 104–08.

[231] SAKALA & CORRY, *supra* note 205, at 11, 13 (billed procedures include, induction, manually assisted delivery, cesarean section, repair of obstetric laceration, circumcision, prophylactic vaccinations and inoculations, fetal monitoring, catheterization, artificial rupture of membranes, blood transfusion, vascular catheterization, not heart, and other therapeutic procedures). If even 5% of current hospital birth became out-of-hospital births it could save Medicaid and Private Insurance 1.3 billion dollars a year. Anderson, *supra* note 220.

[232] SAKALA & CORRY, *supra* note 205, at 12.

[233] SAKALA & CORRY, *supra* note 205, at 14. At first thought this may sound reasonable since caesarean sections are surgical procedures, but it is also a very common surgery that takes less than thirty minutes. In contrast, a home birth midwife might be attending a client in a more intense, hands-on way for hours on end before a natural vaginal birth.

[234] In 1988 when Medicare recognized Certified Nurse Midwives as maternity care providers for its 3 million Medicare eligible women, it also established their reimbursement rate at sixty-five percent of the physician's rate, resulting in the 111st Congress considering a bill to rectify this. Also, only about fifty percent of states provide 100% reimbursement to CNMs under Medicaid. *Medicaid Reimbursement by State*, AMERICAN COLLEGE OF NURSE MIDWIVES (April 2009), http://www.midwife.org/siteFiles/legislative/Medicaid_Reimbursement_by_State_4_09.pdf.

[235] Another cost that would be interesting to compare is the cost of education: analyzing the data to compare the cost of becoming an OB/GYN, versus a family doctor, a nurse-midwife, or a direct entry midwife would be interesting. Not only would I like to see these numbers evaluated in terms of cost to

For consumers, the economic issues are slightly different than for practitioners. Insurance coverage for home birth is inconsistent.[236] State law generally regulates insurance, but ERISA exempts some companies from state laws, and the Affordable Care Act has established new guidelines with regard to "essential benefits."[237] Insurance companies in New York are required to reimburse for home births (except for companies exempt through ERISA), but most states do not have laws that require reimbursement for the procedure, and New York does not license direct-entry midwives, only nurse midwives who perform home births.[238] Getting reimbursed by an insurance company requires a lot of advocacy from the consumer, as the insurance company will deny the claims offhand, often referring to AMA or ACOG anti-home-birth policies, or safety concerns.[239] This is counter intuitive because insurance companies would have to pay less on the home birth claims than they do on the hospital birth claims, since home birth costs so much less.[240] Many people pay out of pocket for home birth.[241] In some states Medicaid or another state health insurance option will reimburse, but again, this varies widely and since it is outside the norm, it requires knowledge and advocacy on the part of the midwife, the consumer, and even someone within the bureaucracy.[242] This lack of coverage keeps home-birth from being a viable choice for many families.

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the care provider and cost to the community in terms of federal loans, but also in terms of how the cost of education is redistributed in the industry. If you add the cost of education to the cost of hospital birth, and all the professionals who make that system run, the expense is even more dramatic, especially when compared to the relatively small cost for home birth midwives' education. *See, e.g.*, *2013-2014 Tuition and Fees By Program and Campus*, OHSU SCHOOL OF NURSING (2013), http://www.ohsu.edu.xd/education/schools/school-of-nursing/admissions/tution-fees/upload/tution-sheet-2014-Final.pdf. Since home birth midwives receive less federal funding and support, it would be great to see a study arguing for the cost/benefit of investing in the education of direct entry midwives would be beneficial(as the government has invested in nurse-midwives). *See* Kathleen Fagerlund & Elaine Germano, *The Costs and Benefits of Nurse-Midwifery Education: Model and Application*, 54 J. OF MIDWIFERY & WOMEN'S HEALTH 341 (2009).

[236] *See infra* notes 237-42 and accompanying text.

[237] *See* Fundamentals of Health Law, *supra* note 19, at 235; *see also* 42 U.S.C. § 18053(b)(6)(2012) (the Affordable Care Act mandates that health plans include the essential benefits package).

[238] Mathilde Piard & Michelle Stockman, *Insurance Coverage for Home Birth: A laborious process*, INSIDE HOME BIRTH, http://web.jrn.columbia.edu/newmedia/2008/masters/birth/insuranceindustry.html.

[239] *See* Ronnie Falcao, *How To Get Insurance Reimbursement for Homebirth: Even if You Have an HMO or Your Plan Doesn't Cover Homebirth or Associated Charges,* GENTLEBIRTH, http://www.gentlebirth.org/archives/preApproval.html.

[240] *FAQ – Answers to Frequent Questions about Homebirth and Midwives*, NEW MOON MIDWIFERY, http://www.newmoonmidwifery.com/faq (last visited Mar. 26, 2014)(providing strategies to file for reimbursement and sampling studies that insurance providers often cite to reject coverage).

[241] *Id.*

[242] New Mexico is well known for its patient friendly laws and Medicaid reimbursement program, but the Medicaid reimbursement program took a lot of advocacy. *See* American College of Nurse-Midwives, *Medicaid Fee-for-Service Reimbursement Rates for CNMs and CMs as of September 2013*, www.midwife.org/ACNM/files/ccLibraryFiles/Filename/000000003389/091713%20ACNM%20Compilation%20Fee%20for%20Service%20Rates.pdf; Falcao, *supra* note 239. *See also* E-mail from Susan Jenkins, esq. Counsel, The Midwife Plan, to Indra Lusero, author (May 10, 2010, 6:34:46 MDT) (on file with author) (discussing her advocacy on the New Mexico Medicaid reimbursement issue).

The bottom line is that maternity care is an industry. And because there are so many economic players, the system is structured in ways that exclude home birth midwives and ensure that they do not expand their share of the market. This exclusion is sometimes intentional, and at other times, just an effect of the enormity of the industry and the bureaucracies involved.[243]

CONCLUSION

All of these structural limitations have to do with who had the money and access to get the ear of decision maker. A critical analysis of modern maternity care in the United States requires recognition that the effort to make midwifery impossible has been largely effective. As discussed above, home birth midwives are a small constituency with limited resources.[244] These economic realities are connected to other bureaucratic and political interests detailed above. The professionalization of medicine coincided with industrialization, the development of new economic and political forces, and the development of new bodies of law.[245] And, it also coincided with a deliberate attempt to eliminate midwifery.[246] Forces set in motion one hundred years ago are at still at work today necessitating certain choices and eliminating others. Efforts to improve the maternity care system should take this reality into account.

Another example is from Colorado where a "chip" program administrator had a home birth and advocated for midwives to be included as providers. E-mail from Beth Karberg, Registered Midwife, to Indra Lusero, author (May 4, 2009, 9:26:48 PM MDT) (on file with the author).

[243] Miriam Perez, *The Cost of Being Born at Home*, RH REALITY CHECK (Mar. 19, 2009, 7:00 AM), http://www.rhrealitycheck.org/article/2009/03/19/the-cost-of-being-born-at-home.

[244] AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, *supra* note 114.

[245] *See* ROOKS, *supra* note 1, at 11-32; Theodore Silver, *One Hundred Years of Harmful Error: The Historical Jurisprudence of Medical Malpractice*, 1992 WIS. L. REV. 1193, 1196-1197 (1992).

[246] ROOKS, *supra* note 1, at 22. And to the extent that doctors continue to engage in tactics that would eliminate midwifery for economic reasons there may be antitrust claims to consider. Consider the combination of VBAC bans in hospitals and insurance companies that refuse to reimburse for home births, along with VBAC bans for home-birth midwives – this creates an economic situation where certain businesses benefit and others are eliminated from competition. This is beyond the scope of this paper but is worth considering. *See generally*, Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L. J. 1071 (1984)(discussing the use of "essential-facilities" doctrine on the conflict of interest between hospitals and physicians as a result of pressure for cost containment); Wilk v. Am. Med. Ass'n, 895 F.2d 352 (7th Cir. 1990) (a successful antitrust suit brought by chiropractors against the AMA).