Obstructed Birth:
Racism In Midwifery Regulation, The Emergence of the Certified Professional Midwife and The Need For Movement Building

By: Sarah Coburn

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Introduction

The United States faces a deepening crisis in the quality, cost and availability of health care. Maternity care in particular reflects the basic inefficiencies of the current model – on the one hand too many women receive unnecessarily expensive care due to the overuse of technology, while others cannot access even the most basic services. Midwives are poised to address this problematic distribution of care by providing essential health services that result in excellent outcomes at lower cost than typical care. Any plan for health reform should include support for and expansion of midwifery services.[1]

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[1] MIDWIVES ALLIANCE OF N. AM. ISSUE BRIEF: CERTIFIED PROF'S MIDWIVES IN THE U. S. 2 (June 2008), *available at* http://mana.org/pdfs/CPMIssueBrief.pdf

Midwives have been regarded as important members of communities and as important figures in the lives of individual families for centuries. In the United States, midwifery became heavily regulated and restricted synchronously with the rise of the American medical profession. The restrictions placed on unmedicalized midwives have had an unquestioningly disproportionate effect on low-income women of color – women who have historically relied on lay midwives within their own communities, and who have been without alternatives to the medical industry, with all of its institutionalized racism.

Traditional reproductive rights jurisprudence, specifically the right to privacy doctrine, does not offer legal assurance to those seeking to utilize unmedicalized midwives who often must practice without the protection of the law. Instead of relying on the edict of privacy issued by the reproductive rights community and the courtrooms more generally, midwives and their supporters must organize legislatively and within activist communities in order to see unmedicalized midwives gain legal and cultural recognition so that their culturally competent services may be made available to women who would otherwise have no alternative to birthing in a hospital with a physician. This paper will focus specifically on Certified Professional Midwives – those midwives who are interested in professionalization but who also reject the medicalization[2] of their practice.

Part I of this article comment discusses the history of midwifery in the United States. That history illustrates a well-developed and strategic approach to midwifery

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[2] Medicalization has been described as the process by which human conditions come to be defined and treated as medical conditions or diseases, and come under the authority of doctors to diagnose or treat. *See* JACQUELYN S. LITT, MEDICALIZED MOTHERHOOD: PERSPECTIVES FROM THE LIVES OF AFRICAN-AMERICAN AND JEWISH WOMEN 4 (Rutgers University Press 2000).

regulation that ultimately resulted in poor communities, specifically communities of color, without access to culturally competent maternity care. The different categories of credentialized midwives that exist today is also explored in detail, with an emphasis on the development of the Certified Professional Midwife (CPM) – an unmedicalized, professional midwife who has completed a prescribed course of education and/or training but whose practice exists wholly outside of the hospital setting. It also discusses the benefits unmedicalized midwives offer and the ways in which the use of their unique model of care might improve the health and lives of low-income women of color.

Part II discusses the varying restrictions placed on unmedicalized midwives. Insurance coverage, specifically limitations on the availability of Medicaid funds for the use of CPMs, creates an important barrier to accessing the unique kind of care that they provide.

Certified Professional Midwives face numerous types of statutory restrictions on their practice. Some are old laws that still persist, dating back to the medical profession's attempts to do away with midwifery in the early part of the twentieth century. Others have been newly enacted or implemented in an effort to quell or control the growing interest in alternative birthing care.

The various claims that midwives and supporters have unsuccessfully raised in courtrooms are detailed. The history of reproductive rights jurisprudence and the ways in which it falls short of addressing the specific needs of birthing women and low-income women of color are also addressed. This history is meant to highlight the shortcomings of the choice movement and the need for a more comprehensive approach to reproductive rights across the full spectrum of pregnancy.

Part III examines the various ways of expanding access to CPM care, including state based legislative campaigns, and national health care reform and legislation. Ultimately, the comment argues that a national licensure scheme is necessary in order to see widespread legal and cultural recognition of unmedicalized midwives so that they might be readily accessible to the communities that would benefit most from their care. Activating the reproductive justice movement and communities of color is ultimately necessary to ensure that CPM care remains culturally competent and relevant to the lives of the women it has the potential to benefit the most.

I. Midwifery in the United States

A consideration of midwifery's history in the United States is necessary in order to fully understand the profession, as it exists today. Midwives in the United States have lesser legal protections and cultural trust than their counterparts in other countries, and black midwives, specially, have historically been treated differently by the medical profession than their white equivalents have. A lack of strategic organization within the profession across racial and economic lines led to the medical profession successfully advocating for crippling legislation and policies that ultimately persist today.

In the face of widespread criminalization in the early twentieth-century, two very different branches of professional midwifery have emerged. The Certified Nurse Midwife possesses a nursing degree and has been trained in a hospital, while the Certified Professional Midwife has abstained from formal medical training. Though she adheres to a rigorous course of study and/or pursues years of apprenticeship her practice exists wholly outside of the medical profession.

a. History

The practice of midwifery enjoys widespread acceptance in both the developed and developing world,[3] yet over the course of the past century it has become heavily regulated and even criminalized in the United States.[4] Prior to the development of the medical professional in the 1900s, midwives practiced openly, and assisting with birth was primarily viewed as women's work.[5] As doctors and the medical professional attempted to gain cultural acceptance while facing public resistance, traditional midwives were forced out of their practice with consequences affecting all women. As explained below, the slower demise of black midwives has had a more substantial effect on the low-income women of color they typically served than on other populations.

Midwifery Through the Twentieth Century

At the turn of the twentieth century American doctors trained to be physicians in England before returning to the United States with their newly developed skills,[6] and British medical innovations were utilized by American physicians to gain financial and social status for the then marginalized medical profession.[7] One such innovation was the use of forceps, developed in Britain and utilized to shorten the time of labor.[8] The instrument provided doctors with an advantage over the more traditional midwife who

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[3] JENNIFER BLOCK, PUSHED 13 (Da Capo Lifelong Books 2007).
[4] Across the Western World, the practice of midwifery has been affected by the development of the medical profession but only in the United States has midwifery faced eradication. In a 1966 study of maternity care compiled by the International Confederation of Midwives and the International Federation of Gynecology and Obstetrics, the United States was treated as a "special case", "because of its tendency not to recognize midwifery as an independent profession." BARBARA KATZ ROTHMAN, IN LABOR: WOMEN AND POWER IN THE BIRTHPLACE 57 (1991).
[5] A detailed account of women assisting women through childbirth in Colonial America has been complied in RICHARD W. WERTZ & DOROTHY C. WERTZ, LYING IN: A HISTORY OF CHILDBIRTH IN AMERICA 1-26 (Free Press 1977).
[6] BLOCK, *supra* note 3 at 29.
[7] WERTZ & WERTZ, *supra* note 5 at 42.
[8] *Id.* at 41.

had no such technology;[9] and innovations like it, coupled with industrialization allowed medical professionals and eventually hospitals to speed-up and create a "painless" birth process.[10]

Doctors and their "new midwifery" thus began to seriously encroach on the practice of traditional midwives. Although there were early attempts to partner with one another,[11] American women lacked the monetary and/or social capital to attend male-dominated medical schools and join the medical profession. They also did not regard the practice of midwifery as requiring formalized education.[12]

In spite of the attempts of the rapidly developing medical profession to infringe on midwifery, the practice continued to thrive in the United States well into the twentieth century. Midwife attended homebirths accounted for more than half of births in the United States up until 1900.[13] In the early twentieth century the number of midwives was double the present number of practicing obstetricians, but the population was one-third of its current size.[14]

The status of midwives shifted dramatically in the first half of the twentieth century[15] when a systematic campaign against midwives was launched. The campaign was spearheaded by the American Medical Association (AMA) whose members viewed

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[9] *Id.*

[10] DEBRA ANNE SUSIE, IN THE WAY OF OUR GRANDMOTHERS: A CULTURAL VIEW OF TWENTIETH-CENTURY MIDWIFERY IN FLORIDA 3 (2009).

[11] *See* WERTZ & WERTZ, *supra* note 5 at 44 (describing attempts in 1817 to establish a midwifery school that would be connected to a hospital).

[12] *Id.* at 45.

[13] JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILD-REARING IN AMERICA, 1750-1950 12 (Oxford University Press 1986).

[14] In 1923 an estimated 60,000 midwives were practicing in the United States. BLOCK, *supra* note 3 at 213.

[15] Midwives attended about fifty percent of births in 1900, and only 1.5 percent in 1935. JUDITH P. ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 30 (Temple Univ. Press 1997). By 1932 roughly eighty percent of midwives practicing in the United States were in the rural south. *Id.*

the midwives as professional competition.[16] Physicians took to podiums at medical conferences and wrote to medical journals to advance the position that childbirth complications and infant and maternal mortality rates were attributable to “the midwife problem”[17] meaning that the unsanitary, uneducated, and unregulated women who delivered babies were to blame for the alarming infant and maternal mortality rates across the country. [18]

More recent analysis of the data medical professionals relied on in reaching the conclusion that the services provided by midwives were unsafe finds that the care doctors provided was not better than that of midwives, and that the intentions of those opposed to midwifery were not necessarily transparent. Infant and maternal mortality rates did not decrease as the field of obstetrics developed.[19] Additionally, the kinds of regulations placed on midwives as a result of the medical profession’s opposition varied depending

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[16] LAURIE A. WILKE, THE ARCHAEOLOGY OF MOTHERING 197 (Routledge 2003).
[17] BLOCK, *supra* note 3 at 213.
[18] At the beginning of the 20th century, for every 1000 live births, six to nine women in the United States died of pregnancy-related complications, and approximately 100 infants died before their first year. The Center for Disease Control, *Achievements in Public Health, 1900-1999: Healthier Mothers and Babies*, 48(38) MORBIDITY AND MORTALITY WEEKLY REP. 849 (Oct. 01, 1999) (citing R.A. MECKEL, SAVE THE BABIES: AMERICAN PUBLIC HEALTH REFORM AND THE PREVENTION OF INFANT MORTALITY, 1850-1929 (1990); I. LOUDON, DEATH IN CHILDBIRTH: AN INTERNATIONAL STUDY OF MATERNAL CARE AND MATERNAL MORTALITY, 1800-1950 (1992)), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm.
[19] A 1912 survey of professors that inquired about the safety of midwives compared with physicians, found 54 percent felt that more women died of puerperal sepsis in the hands of physicians, 18 percent thought the rates were equal, and the remaining 28 percent said they did not know. In addition, 93 percent thought that more women died "as the result of ignorance or of ill-judged and improperly performed operations in the hands of general practitioners as from puerperal infection in the hands of midwives.” I. W. Williams, *Medical Education and The Midwife Problem in the United States*, 58 J. OF THE AM. MED. ASS’N, 1-7 (1912). In 1913 it was reported in New York City midwives attended 40 percent of all births but had only 22 percent of maternal deaths from puerperal sepsis, whereas physicians with 60 percent of the births had 69 percent of the deaths from sepsis in their practice. J. Backer, *The Function of the Midwife*, 23 WOMEN’S MED. J. 196-97 (1913). *See also,* Julius Levy, *The Maternal and Infant Mortality In Midwifery Practice in Newark, New Jersey*, 77 AM. J. OF OBSTETRICS 41 (1918) (reporting per a study conducted by the New Jersey State Department of Public Health that in Newark for 1915 and 1916 midwives had significantly lower rates of infant and neonatal deaths than did physicians); T. Haley, *A Children's Bureau Survey: Infant Mortality In Akron, Ohio*, 72 CHILDREN’S BUREAU PUB. (1920) (finding that although there was a significantly higher infant mortality rate among the clients of midwives than among those of physicians in Akron, the mortality rate could be attributed the difference to the poverty of the midwives' clients).

on the race and the socio-economic status of the midwives' and their patient population.[20] Nonetheless, by 1930, despite evidence concluding homebirth's safety, [21] all but ten states restricted the practice of midwifery. In 1950, nearly ninety percent of women birthed in hospital and midwives attended less than ten percent of all deliveries,[22] limited almost entirely to a few southern and western states.[23]

Black Midwives

The history of black midwives in America is a storied one that begins with enslaved African women who were brought to the United States to work on plantations. After emancipation, black midwives provided assistance to their own communities. Although the medical profession recognized that they provided essential services to rural and poor areas, [24] the black midwives were nonetheless systemically restricted practicing as the medical profession found opportunities for itself within the midwives' client populations.

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[20] Without a strong vital statistics program in the United States, physicians could attack the safety and credibility of midwives with little fear of recourse. Until the twentieth century, American midwives did not have any sort of professional organization like the Midwives Institute in England. Founded by midwives in 1881, the Institute successfully lobbied for legal recognition. Neal Devitt, 4(2) WOMEN & HEALTH 169, 182 (1923).

[21] ROOKS, *supra* note 15 at 28. A decline in infant and maternal mortality rates could not be statistically correlated to the emergence of hospital births, given that the decline did not occur until after World War II, though births steadily moved from the home to the hospital between the years 1900 and 1950. BLOCK, *supra* note 3 at 214. A study conducted by the Committee on the Costs of Medical Care reported in May 1927 that the "midwife is not the determining factor in the country's high maternal mortality rate…untrained midwives approach, and trained midwives surpass, the record of physicians in normal deliveries." Devitt, *supra* note 20 at 178.

[22] LITT, *supra* note 2 at 5; LEAVITT, *supra* note 13 at 171.

[23] BLOCK, *supra* note 3 at 216.

[24] "It appears to us that for some time to come midwives, like poor relations, will always be with us; and certainly in many areas they fill a much needed gap in the number of professional personnel and the availability of services. This being the case, every attempt should be made by all health units confronted with this problem to develop plans for their improvement." Paul B. Cornely, *Trends in Public Health Activities Among Negroes In 96 Southern Counties During the Period 1930-1939: II. Comparison of Certain Health Services Available for Negroes and White Persons*, 78 AM. J. OF PUB. HEALTH 1117, 1122 (Oct. 1942).

Beginning in 1619 the African "grannie" midwife existed in America having arrived with the first ships of African slaves.[25] By 1860 there were approximately four million slaves in America,[26] and the vastness of the plantation system required that organized medical care be provided on site.[27] Enslaved women, usually those who were older and no longer capable performing manual labor, were appointed as plantation midwives and not only did they help birth babies, but they also dispensed medicine and performed cesarean sections.[28]

After emancipation in 1863, medical services for African American communities were sparse and under-funded,[29] and midwives continued to offer important services. These women, typically female descendants of enslaved midwives, were trained by their mothers and female relatives. They became community stalwarts and functioned as liaisons between the community and the few accessible health professionals and institutions.[30]

In 1921, Congress passed the Sheppard-Towner Act[31] and provided grants that encouraged states to establish formal relationships between public health nurses and

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[25] Ahron A. Robinson, *A Historical Development of Midwifery in the Black Community: 1600-1940*, 29(4) J. OF NURSE-MIDWIFERY 247 (July/August 1984).
[26] *Id.*
[27] *Id.* at 248
[28] *Id.*
[29] "In segregated America, no one took responsibility for the delivery of care for African Americans. Through considerable struggle, black medical professionals began taking charge of care for black Americans. But this transformation was difficult; in the early 1900s blacks were restricted from mainstream professional medical societies, as well as most medical schools. In fact, in 1900 only seven medical schools were training blacks at all. For both African Americans and Mexican Americans, public health and other medical societies did not begin taking responsibility for their health until they were deemed a threat to the health of whites; thus the type of care delivered was generally in the form of hygiene control and treatment of infectious diseases." RONALD ANDERSEN ET AL., CHANGING THE U.S. HEALTH CARE SYSTEM: KEY ISSUES IN HEALTH SERVICES POLICY AND MANAGEMENT 60 (2001) (internal citation omitted).
[30] Robinson, *supra* note 25 at 249.
[31] Sheppard-Towner Maternity and Infancy Act, ch. 135, 42 Stat. 224 (1921), *repealed by* Act of Jan. 22, 1927, ch. 53, S 2, 4 Stat. 1024, 1024. The Sheppard-Towner Act incentivized all but ten states to pass restrictive midwifery laws by tying funds for midwifery education to the implementation of midwifery

midwives working in rural and under-served communities. The public health nurses reached out to grannie midwives and at least in some locations, met with them monthly to discuss problems arising from recent births and to give instructions on basic maternity care.[32] The midwives traveled long distances to attend the trainings. According to anthropological studies these interactions with one another served the importance purposes of skill sharing and community building.[33]

The grannie midwives, so eager to train and appease the state-sponsored nurses, did not realize they themselves were the "midwife problem," and that the training they were receiving would precede the end of their profession. The regulation of the grannie midwives generally conformed to a three-phase plan of education, licensing, and elimination.[34] These plans differed from state to state, but in most instances essential midwives – those who served communities that were rural and inaccessible or distasteful in their poverty and inability to pay for medical services – received training from public health officials. After relationships were cultivated and developed between health departments, midwives, and their patients, licensing requirements were instituted.[35]

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regulation. *See*, J. Stanley Lemons, *The Sheppard-Towner Act: Progressivism in the 1920s*, 55(4) The J. of Am. History 776 (Mar. 1969).

[32] Robinson, *supra* note 25 at 249.

[33] In fact, the relationship became an important one. As the home-birth movement of the 1960s and 70s took hold, the remaining grannie midwives leaned heavily on the public health nurses, turning to them to help decipher newly developing legal requirements and rules. SUSIE, *supra* note 10 at *64*-5. *See* discussion on the homebirth movement *infra* Section I.b.ii.

[34] *Id.* at 6

[35] In Virginia, it is reported that the "education and supervisory" approach to midwifery recognized that in rural districts were there were no physicians and as such midwives could not be eliminated. They were a "necessary evil." GERTRUDE FRASER, AFRICAN AMERICAN MIDWIFERY IN THE SOUTH: DIALOGUES OF BIRTH, RACE, AND MEMORY 59 (1998). In 1931 Florida's first midwifery law was passed requiring midwives to attend fifteen births with a licensed registered physician in order receive the certification necessary to continue practicing. 1933 it was estimated that at least one-third of the state's births were midwife-attended. In an effort to locate the 1,400 midwives thought to be practicing in the state, a letter was sent with a voluntary response rate nearing 50 percent. The response serves as evidence of the midwives' belief that the newfound state interest in the practice of midwifery was a positive one. SUSIE, *supra* note 10 at 34-35, 50.

Those regulations generally required some period of training and/or partnerships with physicians or health professions. Eventually the licensing would be restricted or phased out when doctors could find a market within the midwives' communities, leaving the midwives with no legally protected practice and effectively no clientele.[36]

A limited number of black health professionals were practicing at the time midwifery regulation targeted grannie midwives. A 1910 report done to determine the efficacy and necessity of medical schools lead to the closing of those schools that had opened their doors to female and black students, finding them to be unnecessary.[37] In 1930, there was approximately one black physician for every 3300 black people, whereas there was one white physician for every 500 white people.[38] Additionally, and in spite of the advances in medical science, the typical rural black doctor was inadequately trained.[39] The first midwifery-training program for black public health nurses was established at the Tuskegee Institute in 1941, yet a total of only 25 midwives were graduated over a five-year period.[40] As a result, if black individuals were to receive medical care, it was likely to come from a white health professional or a grannie midwife. However, as the grannies were pushed out of the profession, many disenfranchised black communities were left without any culturally competent resources.

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[36] In Florida the permits ultimately created impossible barriers for the grannies: licensure would not be renewed if the midwife had not attended any births in two years. Additionally, physician partnerships were required, with ultimately served as a proselytizing device for clients. SUSIE, *supra* note 10 at 53. As funding for health care for the poor and desegregation legislation increased in the 1960s, the presence of physicians in communities of color, the partnering requirement became more pronounced. *Id.*

[37] BARBARA EHRENREICH & D. ENGLISH, WITCHES, MIDWIVES AND NURSES: A HISTORY OF WOMEN HEALERS (1973).

[38] Robinson, *supra* note 25 at 249.

[39] *Id.*

[40] M.W. Thomas, *Social Priority No. 1: Mothers and Babies*, 34 PUB. HEALTH NURSING 442 (1942).

b. The Professionalization of Midwifery

There are, generally speaking, two categories of professionalized midwives Certified Nurse Midwives (CNMs) who have a nursing degree in additional to specialized training pertaining to birth, and Certified Professional Midwives (CPMs) who have specializing and specific training pertaining to the full spectrum of pregnancy and birth, but receive their training outside of a hospital setting. The two professions developed under very different circumstances and their respective training remains pedagogically distinct.

The Certified Nurse-Midwife

A 1935 hospital advertisement showcased the prevailing sentiment among medical professionals when it proclaimed, "[e]very woman in childbirth is potentially a major surgical case."[41] Childbirth, embraced by midwives as a natural process, was now viewed as a dangerous and abnormal condition amongst physicians. The public, regarding the medical industry with increasing deference, soon adopted this sentiment too. As a result, politically disenfranchised midwives moved toward aligning themselves with the nursing profession in an attempt to regain public favor. Their efforts lead to the establishment of a new profession: the Certified Nurse Midwife (CNM).[42]

One of the earliest and most widely recognized CNM programs was established in 1925 by Mary Breckinridge, who had earned her nursing degree in New York City and had come to know European nurse-midwives while volunteering in France following

[41] BLOCK, *supra* note 3 at 217.

[42] Raymond G. DeVries & Rebecca Barroso, *Midwives Among the Machines: Re-creating Midwifery In the Late Twentieth Century Midwives*, *in* MIDWIVES, SOCIETY AND CHILDBIRTH: DEBATES AND CONTROVERSIES IN THE MODERN PERIOD 248, 252 (Hilary Marland & Anne Marie Rafferty eds., 1997).

World War I.[43] Breckenridge believed that the combined skills of nursing and midwifery could be used to serve rural, medically underserved populations.[44] From her team of nurses, she developed the Frontier Nursing Service in Kentucky.[45] Doctors and nurses worked together, and by 1933 the hospital Breckenridge established was lending support to numerous out-post stations that provided remote areas with nursing and midwifery services by horseback.[46]

Breckenridge eventually went on to establish a school, now called the Frontier School of Midwifery and Family Nursing.[47] The school and the others that developed around it[48] emphasized both the practice of midwifery's dedication to serving populations typically excluded from health care,[49] while also remaining inextricably linked to nursing and nursing education.[50] Today Certified Nurse-Midwives (CNMs) continue to embody the duality of a holistic approach to the birth experience, and the disease-oriented care offered in hospitals. Today, care provided by CNMs is typically less expensive than the care offered by obstetricians and physicians,[51] but CNMs practice almost exclusively in hospitals and rarely provide services at home.[52]

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[43] ROOKS, *supra* note 15 at 36.
[44] *Id.*
[45] *Id.* at 37.
[46] *Id.*
[47] *Id.*
[48] The Lobenstine School of Midwifery Association was established by one of Breckenridge's nurse in New York City in 1931. The Frontier Nursing Service opened their own training program in 1939, and in 1941 yet another program opened in Alabama. *Id.* at 37.
[49] ROOKS, *supra* note 15 at 46.
[50] *Id.* at 288-89.
[51] The care provided by CNMs includes fewer medical interventions than the care provided by physicians, thus reducing the cost. *See* Jane Krumlauf, et al., *Certified Nurse-Midwives and Physicians: Prenatal Care Charges*, NURSING ECONOMICS, 1988, at 27-30 (finding that care provided by obstetricians was $548 higher than the care provided by CNMs); *see also infra* note 72 and accompanying text.
[52] Although CNMs educated through the 1950s had experience was homebirths, by 1982 nearly seventy-five perfect had no out-of-hospital experience during their education. Constance Adams, *Nurse-Midwifery in the United States: 1982*, ACNM, Washington D.C., 1984; Sally C. Curtain and Melissa M. Park, *Trends in the Attendant, Place and Timing of Birth, and in the Use of Obstetric Interventions, 1989-1997*, 47

Despite nurse-midwives' gain in recognition throughout the 1950s with formal legal and medical licensure in all fifty states,[53] by the 1970s the profession of midwifery faced a generation of women who had developed a distrust of the rapidly advancing medical industry.[54] Increasingly, women and midwives viewed the services provided by CNMs as little more than obstetrics under the label of midwifery, and actively rejected the formalized medical training that was required of nurse-midwives.[55] The alternative birth movement was thus born as a rejection of the medication profession, an engagement in a holistic approach to birth, and an emphasis on being "with women."

The Certified Professional Midwife

By the 1970s nearly every state had regulated against lay and traditional midwives,[56] or explicitly required that they partner with physicians in order to practice.[57] Continued resistance from the medical profession took the form of physicians refusing to

NAT'L CTR. FOR VITAL STAT. 2-3 (Dec. 1999); Joyce A. Martin et al., *Births: Final Data for 2000*, 50 NAT'L VITAL STAT. REP. 14 (Feb. 2002).

[53] DEBORAH A. SULLIVAN & ROSE WEITZ, LABOR PAINS: MODERN MIDWIVES AND HOME BIRTH 18 (Yale Univ. Press 1988).

[54] DeVries & Barroso, *supra* note 42 at 256.

[55] *Id. See also,* David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 Marq. L. Rev. 975, 1020 (1992) (proposing that the new midwifery movement is a result of women and families resisting "the medical establishment's domination of birth").

[56] The terms "lay midwife" and "direct-entry midwife" have been used interchangeably to describe non-nurse midwives. While Certified Professional Midwives (CPMs) may refer to themselves as lay or direct-entry midwives, not all lay midwives are CPMs. In fact, many midwives reject any professionalization of their practice and have not attempted to nor are they interested in being conferred with the title of Certified Professional Midwife. *See* ROOKS, *supra* note 15 at 225-230 (describing the development of direct-entry midwifery); SULLIVAN & WEITZ, supra note 53, at 101-02 (describing lay midwives' resistance to licensure). For the purposes of this paper, references to lay or direct-entry midwives are meant to describe CPMs or other midwives interested in credentialization.

[57] For example, in 1918 the Virginia General Assembly passed legislation to regulate midwives with little activity or record keeping until the 1950s at which point health departments began requiring pregnant women to gain approval from physicians before having a mid-wife assisted homebirth. Crista Craven, *Every Breath Is Political, Every Woman's Life a Statement: Cross-Class Organizing for Midwifery in Virginia*, *in* MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 311, 336 (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006).

partner with midwives in the states that required collaboration,[58] effectively banning the practice.

The homebirth movement that developed in the 1960s and 70s was primarily white and middle-class. The women now demanding the right to birth at home had greater social capital than the black midwives before them – they had the "education, color and financial means of their caste [which] made them harder to dismiss by those in power."[59] They also, in a relatively short period of time, developed empirical evidence to support what they were proposing: that homebirth was safe, possibly safer than hospital births, and that they had a right to birth where and with whomever they wanted.[60]

The homebirth movement did not develop without strong resistance from the medical profession whose refusal to recognize non-nurse midwives as professionals prompted those midwives unwilling to medicalize to organize amongst themselves.[61] In 1982 the Midwives Alliance of North America (MANA) was formed as a band of traditional midwives offering support to one another and serving as an advocacy tool for the profession.[62] MANA developed a standard of care that honors and includes non-medicalized approaches to midwifery, and founded a certificate program that recognizes

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[58] DeVries & Barroso, *supra* note 42 at 256.
[59] SUSIE, *supra* note 10 at 61.
[60] Pregnancy outcomes of 1707 women, who enrolled for care between 1971 and 1989 with a home birth service run by lay midwives in rural Tennessee, were compared with outcomes from 14,033 physician-attended hospital deliveries derived from the 1980 US National Natality/National Fetal Mortality Survey. Based on rates of perinatal death, labor complications, the use of assisted delivery, and other factors, the survey suggests that home births attended by lay midwives can be accomplished as safely as, and with less intervention than, physician-attended hospital deliveries. Mark Durand, *The Safety of Home Birth: The Farm Study*, 82 AM. J. PUBLIC HEALTH 450 (1992).
[61] DeVries & Barroso, *supra* note 42 at *256.*
[62] DeVries & Barroso, *supra* note 42 at 257.

alternative methods of gaining experience and training. The certificate identifies those who meet the program's requirements as Certified Professional Midwives (CPMs).[63]

Non-medicalized midwifery education takes the form of either class instruction from midwifery schools or apprenticeships that span several years. These approaches to education continue to be pursued because studies and experience show that the more time a midwife spends training in medical facilities, the more medicalized her practice becomes.[64] To further the profession and the pedagogical approach of learning midwifery in an unmedicalized setting, lay midwives have relied heavily on one another and their shared communities.

The Midwifery Model of Care is an approach to pregnancy and birth based on the view that they are not medical emergencies but normal life events,[65] and it is the approach most often taken by CPMs. The model not only emphasizes the natural process, but also provides culturally sensitive[66] and continuous care to the woman throughout her pregnancy.[67] CPMs commit themselves to monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle, while providing individualized education, counseling, and prenatal care, continuous hands-on assistance

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[63] Generally, candidates eligible to apply for the CPM credential are those who have graduated from a program accredited by the Midwifery Education Accreditation Council (MECA), midwives certified by the American Midwifery Board as either CNMs or CMs (certified midwives), or those who have completed NARM's Portfolio Evaluation Process (PEP) Program. The latter option was created to facilitate applicants who are primarily apprentice-trained. The North American Registry of Midwives. Certified Professional Midwife (CPM): Candidate Information Bulletin, (revised Jan. 2010) available at http://www.narm.org/pdffiles/cib.pdf; N. AM. REGISTRY OF MIDWIVES, HOW TO BECOME A CERTIFIED PROFESSIONAL MIDWIFE, http://www.narm.org/pdffiles/htb.pdf.

[64] Laura D. Hermer, *Midwifery: Strategies on the road to Universal Legislation*, 13 HEALTH MATRIX 325, 352 (2003); Susan Corcoan, *To Become a Midwife: Reducing Legal Barriers to Entry Into the Midwifery Profession*, 80 WASH. U. L.Q. 649, 668 (2002).

[65] *See* ROOKS, *supra* note 15 at 275-77 (describing the holistic health care model defined as the model upon which direct-entry midwives base their practice).

[66] *See* SULLIVAN & WEITZ, *supra* note 53 at 75 (discussing elements of midwifery's holistic approach including the midwife's concern with the pregnant woman's social and psychological well-being).

[67] *See* Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 545-46 (1993) (noting that laboring women receive encouragement and assistance from her midwife before, during, and after labor).

during labor and delivery, and postpartum support.[68] Additionally, CPMs seek to minimize technological interventions during birth – an important cost and risk-reducing component of the model of care they employ.

Studies consistently show that planned homebirths for low-risk pregnancies have positive health outcomes for both mother and child.[69] Dating back to 1933 and a comprehensive study done of Mary Breckenridge's Frontier Nursing Service that showed positive outcomes for women assisted by midwives,[70] studies spanning more than seventy-five years confirm that homebirth is safe. Homebirths typically have fewer complications and fewer medical interventions than hospital births.[71] Homebirths also come with the promise of uninterrupted and focused care from a midwife, which stands

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[68] "Midwives offer comprehensive continuity of care throughout the childbearing cycle. This mean women receiving midwifery care can receive preconception counseling; prenatal care. . .labor support; care during and after the birth; breastfeeding support and postpartum follow-up all through the same caregiver. Annemarie van Oploo, *Birthing Naturally With a Midwife, in* ADVENTURES IN NATURAL CHILDBIRTH 22 (Janet Schwegell ed., 2005); NAT'L ASSN. OF CERTIFIED PRO'F MIDWIVES, ESSENTIAL DOCUMENTS OF THE NATIONAL ASSOCIATION OF CERTIFIED PROFESSIONAL MIDWIVES *available at* http://www.nacpm.org/Resources/nacpm-standards.pdf.

[69] The definitive study of homebirth found that babies delivered to low-risk women planning a homebirth under the care of CPMs experience outcomes equal to those of low-risk women giving birth in the hospital, with notably fewer of the costly interventions associated with hospital births, including a five-fold decrease in the rate of cesarean sections. Kenneth C. Johnson & Betty-Anne Daviss, *Outcomes of Planned Homebirths With Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1416 (June 18, 2005).

[70] A study conducted by the Metropolitan Life Insurance Company concluded that if the services provided by the FNS were available all over the country that 10,000 mothers' and 30,000 infants' lives could be saved each year. ROOKS, *supra* note 15 at 37.

[71] *See* Kathleen Carrigan Kelcher & Leon I. Mann, *Nurse-Midwifery Care in an Academic Health Center*, 15 J. OBSTETRIC GYNECOLOGIC, & NEONATAL NURSING 369, 372 (1986) (finding a five-percent reduction in cesarean sections when using midwives as opposed to physicians, and that midwife care, with its reduced cesarean sections rates, had proven to be safe for newborns and their mothers); A Mark Duran, *The Safety of Home Birth: The Farm Study*, 82 AM. J. PUB. HEALTH 450, 451-52 (1994) (finding that the incidence of cesarean sections was more than ten times more likely in hospital births than in midwife assisted homebirths with no increase in maternal or neonatal harm); Patricia A. Janssen et al., *Outcomes of Planned Home Births Versus Planned Hospital Births After Regulation of Midwifery in British Columbia*, 166 CAN. MED. ASS'N J. 315, 319 (2002) (noting that midwives in both hospital and home setting had lower induction rates than physicians).

in contrast to the care offered by doctors and nurses who are required to tend to a number of patients.[72]

A CPM associated care birth is approximately one quarter of the cost of a hospital birth,[73] and less than one-half of the cost of care in a birthing center with a CNM.[74] The cost differential makes the care provided by CPMs especially attractive to under and uninsured people.[75] Utilizing the services of a CPM means not only employing a birth attendant, but also includes months of contact leading up to and following the birth, with mental health and wellness support. CPMs monitor the ongoing physical health of the mother and baby, making the care they provide more comprehensive and holistic than the care offered by many physicians and obstetricians.

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[72] *See* Ehrenreich, *supra* note 67 at 535-50 (discussing why the holistic approach to childbirth and the use of midwives is more positive for women than a medical approach, including the theory that childbirth is a normal process); SULLIVAN & WEITZ, *supra* note 53 at 75 (discussing the elements of the midwives holistic "wellness" approach to birth and labor, and how it contrasts with physicians' disease-oriented medical approach).

[73] Rondi E. Anderson & David A. Anderson, *The Cost Effectiveness of Home Birth*, 44 J. OF NURSE MIDWIFERY 30, 30-5 (Jan. 1999) (finding the average cost of an uncomplicated homebirth with a midwife to be $2,391, adjusted to 2009 dollars using the Consumer Price Index); Margaret Mushinkski, *Average Charges for Uncomplicated Cesarean and Vaginal Deliveries, United States, 1993*, STAT. BULL., Oct.-Dec. 1994, at 27-36 (finding that in hospitals the average cost of a vaginal birth is $8,456, adjusted to 2009 dollars using the Consumer Price Index).

[74] Patricia W. Stone & Patricia H. Walker, *Cost-Effectiveness Analysis: Birth Center vs. Hospital Care*, 13 NURSING ECONOMICS, 299 (1999) (finding that in birth centers the average cost for an uncomplicated delivery is $5,318, adjusted to 2009 dollars using the Consumer Price Index).

[75] In the United States, nearly one in five women of childbearing age (ages 15-44) were uninsured in 2008. March of Dimers, PeriStats. http://www.marchofdimes.com/Peristats/. *See e.g*., Press Release, Maine Ass'n of Certified Prof. Midwives, Maine Association of Certified Professional Midwives Oppose Question One (Oct. 23, 2008) *available at* http://www.macpm.org/Press_ Release_10-23-08.doc (noting that because of the low cost of care, CPMs in Maine treat a disproportionate number of the state's under insured and uninsured women); On-line chat transcript, RH Reality Check Making "My Birth, My Choice" A Reality For All Women, *available at* http://www.coveritlive.com/index2.php?option=com_altcaster&task=viewaltcast&altcast_code=9996d8a97a&ipod=y (noting that the care they provided by CPMs is cheaper than obstetrics and that they see many uninsured and underinsured women).

The Benefits of Certified Professional Midwifery Care For Low-Income Women of Color

The model of care employed by CPMs offers unique benefits to low-income women **of c**olor. CPM care allows women to experience control over and develop an understanding of their bodies, and as a result the homebirth experience may have a substantial effect on groups typically disempowered and marginalized by the medical industry.[76] Because the unique benefits associated with CPM care are unlikely to be offered by doctors and other medical professionals, it is imperative that CPMs achieve general acceptance in order to make their services more widely available.

The Midwifery Model has been described as "an essential element of comprehensive care for women," focusing on the normalcy of pregnancy and childbirth.[77] This holistic model stands in contrast to the medicalized birth experience that objectifies pregnant women, treats pregnancy like a disease, and uses aggressive interventions — all while placing ultimate authority and responsibility in the hands of a physician.[78] Focusing not only on the birth experience itself, the holistic model seeks to create and maintain general health. In underserved communities, this care may be the only time a woman will receive such regular and intensive education on her health and well being.[79] Accordingly,

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[76] "Within a relationship that develops between a midwife and a pregnant woman over the many months of pregnancy, women who have had few successes in their lives can be helped to deal with problems successfully and can experience their pregnancies and births in a way that empowers them. . ." ROOKS, *supra* note 15 at 478.

[77] Catherine M. Dower et al., *Charting a Course for the 21st Century: The Future of Midwifery*, 16(1) BIRTH GAZ. 19 (Winter 2000).

[78] ROOKS, *supra* note 15 at 275

[79] This is especially critical as several researchers have suggested that health illiteracy is a potential cause of health disparity. *See generally,* Julie A. Gazmararian et al., *Public Health Literacy in America: An Ethical Imperative*, 28(3) AM. J. PREVENTATIVE MED. 317-22 (2005); COMM. ON HEALTH LITERACY & BD. ON NEUROSCIENCE AND BEHAVIORAL HEALTH, HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION (Lynn Nielsen-Bohlman, Allison M. Panzer & David A. Kindig eds., 2004).

the model offers the possibility of long-lasting positive effects on communities reaching beyond greater access to health care.

CPMs offer an approach to health care that takes the difficultly of being poor into account while addressing the powerlessness that some low-income women of color may feel.[80] The midwifery model of care enables midwives to help their clients become self-determining – in this way clients may learn how to make decisions about their fertility that enables them to make other important life decisions and become leaders in their communities.[81]

While the medicalization of the birth process affects all women, white women generally enjoy greater access to and comfort with the medical profession.[82] Low-income women of color have long battled the medical industrial complex with striking examples found in recent history. In the 1970s sterilization became the most rapidly growing form of birth control in the United States, rising from 200,000 cases in 1970 to over 700,000 in 1980.[83] Throughout this time, it was common practice for major teaching hospitals to perform hysterectomies on poor black and Puerto Rican women with minimal

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[80] *See,* JAEL SILLIMAN et al., UNDIVIDED RIGHTS 66 (South End Press 2004) (discussing the impetus behind the formation of a midwifery center opened in Gainsville, Florida).

[81] *Id.* at 126

[82] A decade after U.S. Surgeon General David Satcher called for the elimination of racial disparities in health, women of color in every state continue to fare worse than white women on a variety of measures of health, health care access and other social determinants of health. News Release, Kaiser Family Foundation, Sizable Health Disparities Evident In Every State Between Women of Different Racial and Ethnic Groups (June 10, 2009) *available at* http://www.kff.org/minorityhealth/rehc061009nr.cfm. Low-income women and women of color face significant hurdles in accessing healthcare including discrimination, inflexible work schedules, and inadequate childcare and transportation. If they are turned away from healthcare providers, they may not have the resources to locate another physician or healthcare facility and make arrangements for a second visit. Bethany Sousa, *New HHS Regs Would Hit Low-Income Women, Women of Color Hardest*, RH REALITY CHECK (Sept. 22, 2008), *available at* http://www.rhrealitycheck.org/blog/2008/09/19/new-hhs-regs-would-hit-lowincome-women-women-color-hardest. In addition to a lack of child care and adequate transportation, a dearth of providers willing to accept public insurance and shortages of providers in rural and inner-city areas compound the problem of access to adequate healthcare. Alyson Reed, *Women's Healthcare Disparities and Discrimination*, 4 C.R. J. (Dec. 2009).

[83] THOMAS M. SHAPIRO, POPULATION CONTROL POLITICS: WOMEN, STERILIZATION, AND REPRODUCTIVE CHOICE (Temple University Press, 1995).

indications, in order to train residents,[84] and reports of medically unnecessary and nonconsensual sterilizations were widespread.[85]

Women of color, like the vast majority of American women, have turned to the medical profession for their prenatal, obstetrics, and birthing needs despite the medical industries historical exploitation of them and the fact that the services may ultimately be detrimental to their wellbeing[86] Of course their reasons for doing so are both obvious and complex.[87] Medicaid policy is one reason. Although racial and ethnic minorities make up roughly one-third of the population in the United States, they comprise more than one-half of Medicaid recipients.[88] In 2006, Medicaid provided coverage for 41% of all births in the United States.[89] With only eleven states authorizing Medicaid coverage of CPM care, Medicaid recipients have little choice of pregnancy related care providers. They

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[84] BETSY HARTMANN, REPRODUCTIVE RIGHTS AND WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL 255 (South End Press, 1995).

[85] *See,* Julias Paul, *The Return of Punitive Sterilization Proposals: Current Attacks on Illegitimacy and the AFDC Program*, 3 L. AND SOC'Y REV. 77, 92 (1968) (reporting that in 1965 it had been alleged that 60 percent of black women in a Mississippi county were subjected to postpartum sterilizations without their permission.); Carl M Cobb, *Students Charge BCH's Obstetrics United with 'Excessive Surgery,'* B. GLOBE, April 29, 1972 (reporting that hysterectomies were performed on black patients for trainings purposes, that safer alternate processors were not used, and that patients were pressured into signing consent forms).

[86] Institutional racism in healthcare is well documented and written about. *See e.g.,* J. Goldberg et al., *Understanding Health Disparities*, HEALTH POLICY INST. OF OHIO 3 (November 2004); Marianne Engelman Lado, *Unfinished Agenda: the Need for Civil Rights Litigation to Address Race Discrimination and Inequalities in Health Care Delivery*, 6 TEX. F. ON C.L. & C.R. 1 (2001); René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191 (1996); COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *Black-White Disparities In Health Care*, 263 J. of the Am. Med. Ass'n 2344 (1990).

[87] When state Medicaid managed care programs allow medically indigent women to obtain care from private physicians and private hospitals, it may be the first time those women have been offered a choice in healthcare, and many want to use the same doctors and facilities used by women who are not poor. ROOKS, *supra* note 15 at 478. Women who do turn to stigmatized forms of health care out of necessity, like homebirth before it became fashionable in the wake of Ricki Lake's film *The Business of Being Born*, typically receive "'damaging cultural narratives' about their biological inferiority and maternal inadequacy." LITT, *supra* note 2 at 29.

[88] RICHARD GONZALES, "REFORMING MEDICAID": HOW STATE WAIVERS WILL HURT RACIAL AND ETHNIC MINORITIES 1 (Families USA eds., Nov. 2005).

[89] THE HENRY J. KAISER FAMILY FOUND., FACT SHEET: WOMEN'S HEALTH POLICY FACTS, WOMEN'S HEALTH INSURANCE COVERAGE 2 (2008), *available at* http://www.kff.org/womenshealth/upload/6000_07.pdf.

often do not have access to CPMs, and in many instances even generalized obstetric care outside of a hospital setting is not an option.[90]

Receiving pregnancy and childbirth related care in the absence of any health insurance including Medicaid is an issue for up to a third of all black Americans – those who earn too much to qualify for Medicaid while working low paying jobs that do not offer health insurance.[91] While some CPMs have seen a growth in their practice with uninsured clients embracing the relatively affordable care midwives provide,[92] lack of knowledge about the practice and lack of targeting by homebirth and CPM advocates keep low-income women from utilizing these services.[93]

By serving as an entry point for addressing many otherwise unattended issues that low-income women of color typically face, CPM care can help combat poor nutrition, chronic emotional stress, and other matters of concern.[94] To effectuate the positive effects

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[90] At least some utilize hospitals because, relative to most primary care doctors, obstetricians and gynecologists have been less likely to accept Medicaid patients. Lorna McBarnette, *Women and Poverty: The Effects on Reproductive Status*, *in* TOO LITTLE, TOO LATE, 55, 57 (Cesar A. Perales & Lauren S. Young eds., 1988).

[91] Black adults have significantly higher uninsured rates than white adults: 33 percent —more than 6 million people—reported they were uninsured at some point during 2005, compared with one of five (20 percent) white adults. Low rates of employer-sponsored coverage partly explain the high-uninsured rate among African Americans relative to whites: only 53 percent of working-age African Americans have insurance coverage through their employer or that of a family member, well below the average for white working-age adults (71 percent). Michelle M. Doty and Alyssa L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults Findings from the Commonwealth Fund Biennial Health Insurance Survey 2005*, Issue Brief, The Commonwealth Fund (Aug. 2006). In 2008 the CDC reported that African-Americans (19.6 percent uninsured) and Hispanics (32.7 percent) were much more likely to be uninsured than white, non-Hispanic people (11.3 percent), however the recent recession has likely caused that number to increase significantly. Carmen DeNavas-Walt et al., *U.S. Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States 2008* (Sept. 2008) *available at* http://www.census.gov/prod/2009pubs/p60-236.pdf.

[92] *See* Miriam Perez, *Delivering Affordable Healthcare*, THE AM. PROSPECT, July 8, 2009, *available at* http://www.prospect.org/cs/articles?article=delivering_affordable_healthcare (reporting that a northwestern midwife has seen a growth in her practice with uninsured patients choosing "[her] services (. . . around $3,000) rather than pay out of pocket for a hospital birth (around $8,500) or even the high deductible for their insurance plan.").

[93] Miriam Perez, *Barriers to Home Birth Fall in Washington State*, RH REALITY CHECK, May 7, 2009, *available at* http://rhrealitycheck.org/blog/2009/05/07/barriers-home-birth-fall-washington-state.

[94] ROOKS, *supra* note 15 at 478.

of the care provided, CPMs need to be made widely available and achieve greater cultural recognition.

It should be noted that CPMs do not practice exclusively in homes, and in some states are more likely to be found in birth centers.[95] Much of the literature developed in support of CPM licensure has been compiled and authored by homebirth advocates and as such reflects as emphasis on the homebirth setting. However, the uniquely beneficial care offered by CPMs is not exclusive to homebirth and can be made available to women who cannot or would rather not birth at home which may be of particular concern in densely populated communities, multi-generational and densely packed households, and for those individuals who do not feel safe at home or are homeless.

II. Restrictions on Access to and The Regulation of Midwifery Care

Although Certified Professional Midwives (CPMs) and their practice differ in innumerable ways from the grannie midwives of the past, they are still subject to the cultural resistance that was cultivated by the medical profession as it developed, and the rules and regulations that were enacted to prohibit or restrict the grannies' practice. And, despite the cultural capital of the new midwifery and its supporters, meaning those who are generally white and educated with social and professional mobility, CPMs still face significant hurdles and set backs from the medical industry, the law, and the public more generally.

Insurance Coverage For Midwifery Care

Currently, as in the past, the American Consortium of Obstetrics and Gynecology (ACOG) "does not support the provision of care by lay midwives or other midwives" and

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[95] *See e.g.,* Texas Midwives – CNMs and Licensed Midwives http://www.texasmidwives.com/TexasMidwivesChart.asp (last visited Feb. 20, 2011) (noting that in Texas licensed midwives, including CPMs, attended to 2,663 births in birth centers and 939 homebirths in 2002).

does not support "programs or individuals that advocate for or who provide out-of-hospital births."[96] The stance taken by these powerful organizations has a considerable impact on the health insurance industry, and insurance policy.[97] In 2008, the AMA issued organizational objectives that place it firmly and definitively at odds with CPMs. The resolutions state that the AMA will "only advocate in legislative and regulatory arenas for the licensing of midwives who are certified by the American College of Nurse-Midwives," thus formalizing the idea that CNMs should be the only legally recognized form of midwife.[98] As a result, the private insurance industry, which often defers to the AMA, has been reluctant to provide coverage.

Medicaid currently provides reimbursement for CPM-assisted home birth in ten states.[99] The Centers for Medicaid and Medicare (CMS) create and interpret federal Medicaid laws and policy and have the ultimate authority over states' ability to administer their state-based Medicaid programs, which are partially funded by the federal government.[100] Although Medicaid does not list CPMs or other direct entry midwives as birth providers, it does permit states to offer reimbursement to any health professional licensed in the state.[101] Because CMS has interpreted the Medicaid laws as excluding birth-centers and other alternative sites from coverage, those fees cannot be paid through

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[96] BLOCK, *supra* note 3 at 264.

[97] *See e.g.,* Policy No. 0329, Aetna Clinical Policy Bulletin: Home Births, *available at* http://www.aetna.com/cpb/medical/data/300_399/0329.html (last visited Dec. 21, 2009) (citing ACOG's statement that labor and delivery clearly presents hazards to both the mother and fetus that require standards of safety which are provided in the hospital setting and cannot be matched in the home, as reason for refusing to cover home births).

[98] American Medical Association House of Delegates Resolutions Report of Reference Committee B 204, 239 (2008) *available at* http://www.amaassn.org/ama1/pub/upload/mm/471/annotatedb.doc.

[99] Alaska, Arizona, California, Florida, New Hampshire, New Mexico, South Carolina, Vermont, and Washington State all offer reimbursement for CPM care through their state Medicaid programs. *See, infra* note 103 and accompanying text.

[100] Medicaid and Birth Centers: Background Information | American Association of Birth Centers, http://www.birthcenters.org/legislative-alerts/index.php?id=17 (last visited Feb. 28, 2011).

[101] *Id.*

any state's Medicaid program.[102] As a result, midwives, including CNMs working in birth centers, homes, and other alternative sites are reimbursed at a lower rate than physicians are and with payments limited to professional fees.[103]

The issue of equitable, nation-wide Medicaid reimbursement is unlikely to be resolved until CPMs can be licensed in all fifty states, because it requires Congressional action. However, when that task is taken up, advocates should attempt to advocate not only for Medicaid coverage but also for coverage under the Medicare, the Federal Employee Health Benefits Plan,[104] the National Health Service Corps,[105] and the Indian Health Service[106] in order to enable CPMs to reach large cross-sections of the population that do not currently have the benefit of access to their services and whom are reliant upon public insurance scheme that might not allow access to many forms of culturally competent care.

Legislation

At the turn of the century, with the AMA's systematic campaign against midwives in full swing and the Sheppard-Towner Act[107] in place, states began enacting statutes to limit or prohibit midwives from practicing and many of those laws remain in place. Those statutes, coupled with more recent legislation, have left CPMs severely limited in how and where they may practice in the United States. The type of restriction

[102] *Id.*
[103] *Id.*
[104] The program provides insurance to federal employees. U.S. Office of Personnel Management – Federal Employees Health Benefits Plan, http://www.opm.gov/INSURE/HEALTH/INDEX.ASP.
[105] The Corps provides funding to areas in the U.S. that have medical, dental and mental health care worker shortages. U.S. Department of Health and Human Services, Health Resources and Services Administration: National Health Services Corps, http://nhsc.hrsa.gov/.
[106] The Service is responsible for providing health services to American Indians and Alaskan natives. U.S. Department of Health and Human Services, Indian Health Services, http://www.ihs.gov/.
[107] *See supra* note 31.

placed on CPMs varies, but they all offer significant challenges to obtaining widespread legal and cultural recognition of the practice.

Currently legislation in several states limits or even criminalizes unlicensed medical professionals who act as primary birth assistants[108] and CPMs face injunctions, criminal prosecution, and risk liability for engaging in their practice.[109] While homebirth has been shown to be as safe as the care provided by hospitals, midwives still face the occasional and tragic experience of having an infant or mother die in birth,[110] thus giving rise to serious criminal charges being brought against them.[111] While some midwives have chosen to avoid licensure all together, CPMs have sought licensure, and have essentially made themselves open to being regulated by the state, but are still prohibited

[108] The Midwives Alliance of North America provides a regularly updated list detailing the legal status of midwives in each state. Direct-Entry Midwifery State-By-State Legal Status, http://mana.org/statechart.html (last visited Jan. 5, 2010).

[109] *See e.g.,* Wyoming, where midwifery has been considered the practice of medicine and illegal without a license since a statute explicitly excluding midwifery from the practice of medicine was repealed in 2003. WYO. STAT. ANN. § 33-26-103 (repealed 2003). As a result, anyone engaged in the practice of midwifery was engaged in the practice of medicine and faced the full penalty of the law for not being trained and licensed. In 2007 a midwife was charged with involuntary manslaughter and engaging in the practice of medicine without a license following the death of an infant. Sue Merrill eventually plead guilty to murder and accepted one year of supervised probation, $3,100 in restitution, and agreed to discontinue practicing midwifery. Michelle Dynes, *Midwife Pleads Guilty In Death*, WYO. TRIBUNE EAGLE, Nov. 17, 2007, *available at* http://www.wyomingnews.com/articles/2007/11/17/local_news_updates /20local_11-17-07.prt. Merrill had delivered over 400 babies in her twenty years of practice. *Id.* On March 5, 2010 Wyoming's governor signed a bill to license and regulate midwives in the state. Coalition For Illinois Midwifery – Wyoming United To Become The 27th State To Legalize CPMs, http://www.illinoismidwifery.org/content/view/29/1/. Those who worked on the bill cited "organized medicine['s]… realiz[ation] that, between current economic trends and the drive for healthcare reform, the demand for access to CPMs and out-of-hospital maternity care is only going to grow" as explanation for the relatively rapid change in state policy. *Id.*

[110] A 2009 study found that the mortality rate per 1000 births was 0.35 in the home birth group, 0.57 in hospital births attended by midwives, and 0.64 among those attended by physicians. Patricia A. Janssen et al., *Outcomes of Planned Home Birth With Registered Midwife Versus Planned Hospital Birth With Midwife or Physician*, 181 CAN. MED. ASS'N J. 377, 379 (2009).

[111] *See e.g.*, Pam Belluck, *Manslaughter Charges Against Lay Midwife Lead to Mistrial*, N.Y. TIMES, June 5, 2001, *available at* http://www.nytimes.com/2001/06/05/us/manslaughter-charges-against-lay-midwife-lead-to-mistrial.html; Daniel Mallow, *Judge Finds Midwife Not Guilty of Manslaughter*, PITTSBURGH POST GAZETTE, April 23, 2009, *available at* http://www.post-gazette.com/pg/09113/965056-100.stm.

from working in these states.[112] The risk of criminal charges being brought against such licensed midwives has raised alarm among practitioners nationwide.[113]

In other states, CPMs are unregulated and practice without legal protection.[114] In such states midwives are considered "alegal,"[115] meaning that although midwifery may not be specifically addressed by statutes, courts may none-the-less find midwives to be engaging in the practice of medicine, leaving them vulnerable to criminal prosecution.[116] In some of these states CPMs and lay midwives have found some assurance in court rulings that find that they are not engaged in the practice of medicine,[117] but the midwives still lack the protection of legislative recognition and remain vulnerable to criminal prosecution.

In still other states, CPMs are statutorily permitted to practice, but are required to obtain licensure that is currently unavailable.[118] In those states, midwifery is regulated and statutorily recognized, yet health departments or other organizations do not issue the required licenses, thus effectively banning CPMs from practice. These statutes were typically part of the gradual phase-out of grannie midwives during the early and mid-1900s, and today midwives still face charges of practicing without proper certification as

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[112] In Rhode Island, midwives must have attended an educational program recognized by the American College of Nurse-Midwives in order to be certified, prohibiting almost all non-nurse midwives from practicing. Those non-nurse midwives who may legally practice must still pass the same certifying exam administered for CNMs. R.I. GEN. LAWS § R23-13MID (2002), *available at* http://www2.sec.state.ri.us/ dar_filing/ regdocs/released/ pdf//DOH/DOH_424_.pdf.

[113] *See e.g.*, Jessica Reaves, *Use of Midwives Rises, Challenging the State to Respond*, N.Y. Times (Sept. 23, 2010) (reporting that fear of prosecution lead one midwife to leave Illinois and move to Wisconsin where she could practice legally and without fear of prosecution) *available at* http://www.nytimes.com/2010/ 09/24/us/24cncmidwives.html.

[114] *Supra* note 108 and accompanying text.

[115] For one discussion regarding the alegality of midwives *see* Ida Darragh, *The Myth of the "Alegal" Midwife*, *available at* www.fromcallingtocourtroom.net/chap1.htm#alegal.

[116] *See* Goslin v. State Bd. Of Med., 949 A.2d 372 (Pa. Commw. 2008) (determining that a CPM had not violated statutes pertaining to limitations on who may practice medicine, because her work was not the practice of medicine while still failing to affirm any rights or legal status).

[117] *Id.*

[118] *Supra* note 108 and accompanying text.

a result.[119] The rationale behind refusing to offer licensure is speculative and varies depending upon when legislation was implemented and what interest groups were behind its passage,[120] but, in any case, it presents a significant hurdle for CPMs wishing to practice legally.

As a result of the numerous restrictions placed on CPMs and other lay-midwives, CPMs risk criminal prosecution in a number of states and must practice covertly or not at all. CPMs who have faced criminal charges or have challenged restrictive laws have attempted to defend their practices, and the rights of their patients, by making a variety of legal claims. FN Most notably, they have attempted to argue that a woman has a right to privacy with regard to her decisions and actions pertaining to birth. The courts, however, have been almost entirely unwilling to accept such claims.

b. Litigation

Midwives and their supporters have often been unsuccessful in defending CPMs and midwifery practices in the courts. The right to privacy, used to defend the right to abortion has historically disfavored low-income women of color and has similarly proved an ineffective tool for sustaining and developing the right to birth at home with CPMs. Other claims raised by midwives – including equal protection, due process, void for vagueness and restraint of trade – have also proved ineffective, suggesting that CPMs

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[119] In Alabama, lay-midwifery has been legally recognized and protected since 1919. ALA. CODE § 46-168. In 1975 more than 280 lay midwives known to health authorities in the United States, were practicing in Alabama, indicating that they provided care to a large section of the state's population. In 1976 the 1919 law was replaced with the current law, which allows lay midwives to practice, but requires that they obtain a license from the Department of Health. ALA. CODE § 34-19-1 (1976). However, the Department of Health has not issued a lay-midwifery license since 1984. *See* The Law – Alabama Friends of Midwives, http://www.alabamamidwives.com/law/index.html (last visited Jan. 7, 2010).

[120] In Alabama the decision to stop administering licensure is representative of the three-tier phase-out strategy employed in response to the "midwife problem." *See* discussion *supra* § II.ii. In Hawaii, a group of midwives introduced a bill in 1998 that would provide licensure for CPMs. An audit of the bill found that licensure was necessary but that the state did not have sufficient funds to subsidize the program. Midwives Alliance of Hawaii, http://www.midwiveshawaii.com/ aboutmah.htm (last visited January 10, 2010).

will not find favor in the courts and instead should seek legislative support and try to develop greater public support for their practice.

The Right to Privacy

The constitutional right to privacy was developed in the context of abortion rights along the continuum of pregnancy. As a result, the court has found that as a woman's pregnancy approaches full-term the state's interest in the life of the fetus increases, thus severely limiting the application of the right to privacy in the context of birth. In addition to developing in such a way so as to exclude birthing women, the constitutional right to privacy has also excluded low-income women of color from its protection because of limiting judicial decisions and legislation that ultimately go to the question of the fetus and not to the mother.

1. Development of The Right to Privacy

Although informational privacy and a right to privacy grounded in the Fourth Amendment had been previously established, in 1965 the Supreme Court recognized a constitutional right to privacy for the first time when it decided *Griswold v. Connecticut*.[121] The Court determined that a fundamental and basic right existed when it struck down a statute that forbade the use of contraceptives by married couples. It defined a penumbral right to privacy, explaining that the right emanated from several constitutional amendments.[122] The right has generally been viewed as one that protects an

[121] 381 U.S. 479 (1965).
[122] "[S]pecific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. . . . Various guarantees create zones of privacy. The right of association contained in the penumbra of the First Amendment is one, as we have seen. The Third Amendment in its prohibition against the quartering of soldiers 'in any house' in time of peace without the consent of the owner is another facet of that privacy. The Fourth Amendment explicitly affirms the "right of the people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures.' The Fifth Amendment in its Self-Incrimination Clause enables the citizen to create a zone of privacy which government may not force him to surrender to his detriment. The Ninth Amendment

individual's interest in making personal decisions about one's family and lifestyle and paved the way for a long line reproductive rights jurisprudence. Those cases shaped and limited the right, ultimately making it restrictive for birthing women and low-income women, in particular.

In 1973, the Court handed down *Roe v. Wade*,[123] finding that a constitutional right to privacy existed for women seeking abortion care. It limited the right by noting that as a pregnancy advanced, the state's interest in the potential life of the fetus increased and eventually trumped the mother's privacy interests,[124] thereby limiting the right to privacy along the continuum of pregnancy.[125] Two decades later, in the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*,[126] the Court further limited the right of privacy in the context of abortion care when it held that states could require parental consent for a minor's abortion,[127] could require a waiting time between seeking and obtaining an abortion,[128] and could require detailed 'informed consent' about the procedure.[129]

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provides: 'The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.'" *Id.* at 484 (internal citations omitted).

[123] 410 U.S. 113 (1973).

[124] *Id.* at 147-64.

[125] Prior to the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician. *Id.* at 163-64. For the stage subsequent to the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. *Id.* For the stage subsequent to viability the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. *Id.* at 163-65.

[126] 505 U.S. 833.

[127] *Id.* at 970-71.

[128] *Id.* at 966-70.

[129] *Id.*

Despite the plaintiff's urging that the Court retain a strict scrutiny analysis[130] as the test for abortion regulations, the Court reaffirmed *Roe*'s "core holding"[131] – that states may not ban abortions or interfere with a woman's ultimate decision to terminate a pregnancy – while eliminating *Roe*'s trimester framework. In place of strict scrutiny, the *Casey* Court established the lower undue burden standard, thus allowing the regulation of abortion prior to viability based on the state's interest in maternal health and potential life, so long as those regulations did not impose an "undue burden."[132] The Court explained that "[a] finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[133] As a result, *Casey* allowed for extensive regulation of abortion,[134] and created an almost undefeatable state interest in the life of an unborn fetus.

Notwithstanding the subsequent cases that limited its application, *Roe* continues to be regarded as the fundamental case for women's autonomy and reproductive rights. However, the case and its progeny have also been used as a basis for restricting the rights of pregnant women, including the right of a prospective mother to birth naturally.[135]

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[130] Under strict scrutiny, the state must establish that it has a compelling interest that justifies and necessitates the law in question.
[131] *Id.* at 843.
[132] More specifically, the Court stated, "[t]he fact that a law which serves a valid purpose . . . has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause. *Id.* at 874.
[133] *Casey,* 505 U.S. at 877.
[134] *Id.* at 872 ("Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed.").
[135] For example, hospitals in at least a dozen states have obtained court orders to compel unwilling women to have c-sections. Lisa Collier Cool, *Could You Be Forced to Have a C-Section?*, BABY TALK MAGAZINE, May 2005, at 56. A court order was issued forcing Laura Pemberton to deliver via cesarean section though she had elected to birth at home when she was unable to find an obstetrician to assist her with a VBAC -

Additionally, this line of privacy cases has also developed in such a way as to make the right to privacy largely unavailable to younger women, low-income women, and women of color.

2. The Right to Privacy Applied to Low-Income Women of Color

A pregnant woman's right to privacy is limited. As has been discussed and will be explored in greater detail, legal restrictions have been placed on the right to privacy throughout the full spectrum of pregnancy – everything from a woman's decision to terminate a pregnancy to where and when she will give birth. While such restrictions have the potential to affect all women at any stage of their reproductive lives, such restrictions ultimately have a disproportionate effect on low-income women of color.

Although the right to access birth control, affirmed by *Griswold*'s right to privacy holding, was a triumph for many women, it may not be so simply described as an overwhelming victory for women of color. Margaret Sanger, the hailed hero of the women's rights movement framed her crusade for wide-spread access to birth control in terms of eugenics, arguing that such access was the most practical method for reducing the birthrate in "less desirable classes."[136] Her position gained traction and as the right to access birth control became more firmly established, women of color faced forced

vaginal birth after cesarean. "The judge said that my unborn baby was in the control of the state and that it was the state's responsibility to bring that baby into this world safely...[he] pointed his finger at me: 'We are going to do the C-section, and we are going to do it tonight.'" She eventually left Florida and had four more successful vaginal births. Address at National Advocates for Pregnant Women's National Summit to Ensure the Health and Humanity of Pregnant and Birthing Women (January 18-21, 2007) (audio recording on file with NAPW); BLOCK, *supra* note 3 at 246-50; Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999).

[136] MARGARET SANGER, AN AUTOBIOGRAPHY 374-75 (Dover, 1971 [1938]).

sterilizations and other means of forced fertility control.[137] For decades, poor women have not only been subjected to sterilization, but to ready distribution of Norplant and Depo-Provera,[138] in addition to family caps for welfare.[139] By implementing these policies and the like, the government and the medical establishment have effectively infringed upon the right to privacy and autonomy regarding reproductive health for specific demographics of women, particularly low-income women of color who not only have had medical procedures forced on them but are offered limited public support for the families they have or want to have.

The Hyde Amendment, a rider to the annual Labor, Health and Human Services and Education appropriations bill, in effect since 1976, prevents Medicaid and any other federally funded programs from subsidizing or paying for abortion.[140] Essentially, the amendment makes the right to privacy guaranteed by *Roe* an illusory one for poor women who otherwise could not afford the procedure.[141] The same year that the Hyde

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[137] *See* e.g., Susan E. Lederer, *Sex, Race, and Science: Eugenics in the Deep South*, 82(4) J. OF AM. HIST., 1622 (1996) (reviewing EDWARD J. LARSON, SEX, RACE, AND SCIENCE: EUGENICS IN THE DEEP SOUTH (1996)) (noting that "[i]n South Carolina ... in the years between 1949 and 1960, 102 of the 104 sterilizations at the state mental health hospital were performed on black women."). As recently as September 2008, lawmakers were proposing legislation that would provide incentives for poor women to be sterilized. Mark Waller, *LaBruzzo Considering Plan To Pay Poor Women $1,000 to Have Tubes Tied*, THE TIMES PICAYUNE (Sept. 23, 2008), *available at* http://www.nola.com/news/index.ssf/2008/09/labruzzo_sterilization_plan_fi.html.

[138] *See* Darci Elaine Burrell, *The Norplant Solution: Norplant and the Control of African American Motherhood*, 5 UCLA WOMEN'S L. J. 401 (1995) (addressing the legal implication of coercing poor African American women to use Norplant).

[139] Currently twenty states have family cap policies with another two states offering a flat rate of cash assistance regardless of family size. The family cap policies, most of them enacted during welfare reform in 1996-97 deny or reduce cash increments for families over a specified size. NAT'L CONFERENCE OF STATE LEGISLATURES, WELFARE REFORM: FAMILY CAP POLICIES, http://www.ncsl.org/IssuesResearch/HumanServices/WelfareReformFamilyCapPolicies/tabid/16306/Default.aspx.

[140] Current version at Pub. L. No. 111-8, §§ 507-508, 123 Stat. 524, 802-03 (2009).

[141] The effect of the amendment was immediate and dramatic. Before the Hyde Amendment, Medicaid paid for one-third of all abortions in the U.S.; today it pays for less than 1 percent of all abortions. Stanley Henshaw and Lawrence Finer, *The Accessibility of Abortion Services in the United States, 2001*, 35 PERSP. ON SEXUAL AND REPRODUCTIVE HEALTH 16, 20 (2003). The amendment disproportionately affects women of color who are more likely to rely on Medicaid for their family planning needs. Women of color make up 51 percent of non-elderly Medicaid beneficiaries but less than 20 percent of the general population. *Id.* at

Amendment made its appearance, the Supreme Court upheld a similarly designed state statute that denied public funding of abortions not deemed medically necessary, though the state paid for childbirth related expenses.[142] The Hyde Amendment and the Court's approval meant that both the legislative branch and the judiciary endorsed restricting the constitutional right to privacy for women: who are poor enough to qualify for Medicaid.

The conventional privacy rights based framework for understanding reproductive rights has thus proven inadequate for protecting the reproductive autonomy of low-income women of color. As discussed, CPMs provide a service that may be especially beneficial for disenfranchised and underserved populations. However, the right to privacy argument as promulgated through the abortion rights line of cases as also proven insufficient to advance a woman's ability to access such services.

Application to Midwifery

When facing criminal prosecution or licensure removal, midwives have attempted to employ the right to privacy arguments developed and advocated by *Roe* and its progeny. By arguing the right to privacy for midwives and the women who utilize their services have sought to establish the right to dictate the end result of pregnancy and to legitimize the midwives' practice. However, with few exceptions, these claims have been wholly unsuccessful.

In 1976 the California Court of Appeals decided *Bowland v. Municipal Court*,[143] a precedent setting case that held *Roe*'s recognition of the state's interest in the potential

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23. Women of color also are more likely to have unintended births, which could be due at least partially to the ban on Medicaid funding of abortions. One-half of all births to black women are unintended compared to one-third births unintended overall. Shawn Towey, Stephanie Poggi & Rachel Roth, *Abortion Funding: A Matter of Justice*, *in* NAT'L NETWORK OF ABORTION FUNDS POL'Y REPORT 5 (2005).
[142] Maher v. Roe, 432 U.S. 464 (1977).
[143] 18 Cal. 3d 479 (Cal.1976).

life of a fetus allowed the state to limit a woman's right to privacy in childbirth.[144] The court determined that *Roe*'s claim of privacy did not allow a mother "the liberty to choose whomever she wanted to assist in the delivery of the child."[145] Although California eventually provided legal recognition of, and protection for, CPMs,[146] *Bowland* set a firm precedent for other courts meeting challenges by midwives and has been cited by numerous courts across the country.[147] The right to privacy claim continues to be raised yet the precedent is one that does not favor the rights of the mother in the later stages of pregnancy and showcases how limited "choice" truly is.

ii. Equal Protection

Bowland and other state court rejections of right to privacy claims in the context of the right of women to choose their birth attendants have been described as "illogical."[148] Ruth Bader Ginsburg herself has argued that *Roe v. Wade* should have been decided on an equal protection argument, rather than on a right to privacy.[149] The right to privacy has been woefully insufficient to address the needs of woman seeking to exercise

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[144] *Id.* at 495.
[145] The Court reasoned that the privacy right relied upon by the landmark reproductive rights cases did not reach delivery, determining that if the state's interest in the life of the fetus could outweigh the mother's right to terminate at the point of viability, then the interest in the life of the fetus could justify state regulation of whom a woman could choose to assist in her birth. *Id.*
[146] Cal. Bus. & Prof. Code §§ 2505-2521 (West 2009).
[147] Many cases have cited *Bowland*. *See e.g.*, Lange-Kessler v. Dept. of Ed. of the State of N.Y., 109 F.3d 137 (1997) (holding that "the right to privacy does not encompass the right to choose a direct-entry midwife to assist with childbirth"); Sammon v. New Jersey Bd. of Med. Examiners, 66 F.3d 639 (1995) (holding that the right to privacy does not cover "the interest of parents in selecting a midwife of their choice"); Hunter v. State, 110 Md. App. 144 (Md. Ct. Spec. App. 1996) (finding that the regulation of midwifery does not violate a woman's right to privacy); People v. Rosburg, 805 P.2d 432 (Colo. 1991) (holding that regulating midwifery does not violate a woman's right to privacy).
[148] Smolin, *supra* note 55 at 1011.
[149] Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C.L. REV. 375 (1985).

choice and sovereignty over their reproductive health decisions, yet in the context of midwifery care equal protection claims have been equally ineffective. [150]

Although the equal protection claims raised by midwives have proven unsuccessful, there may have been claims based on race that carried a theoretical potential for success. In the case of *State v. Kimpel*[151] the defendant midwife was black and practicing in Alabama, serving her African-American community. She challenged a state law allowing licensed lay-midwives to continue to practice midwifery until their certification ran out, but otherwise restricted their practice entirely.[152] The court ultimately determined the case on a rational basis standard, finding that midwives did not constitute a suspect class that would have demanded a higher level of review.[153] Thus, the midwife's claim failed.

However, the *Kimpel* court failed to address that all of 150 midwives who had lost their licensure as a result of the legislature's Act were black.[154] Unless the midwife had been able to prove that the law had a discriminatory intent, and not just a discriminatory impact, the outcome would not have changed had the court employed a the strict scrutiny analysis,[155] but the case nonetheless presents an interesting and untested angle that black midwives might have had some success with.

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[150] *See e.g.,* People v. Rosburg, 805 P.2d 432 (1991) (holding that the state's prohibition against law midwifery did not impermissibly discriminate between lay and nurse-midwives under the rational basis test, and was rationally related to the legitimate governmental interest in protecting the life and health of the mother and child).
[151] *Kimpel*, 665 So.2d 990.
[152] ALA. CODE § 34-19-3 (1976).
[153] *Kimpel*, 665 So.2d at 994.
[154] MARGARET CHARLES SMITH & LINDA JANET HOLMES, LISTEN TO ME GOOD: THE LIFE STORY OF AN ALABAMA MIDWIFE, 135 (Ohio State Univ. Press 1996). For a discussion of this case *see* Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61 (2004).
[155] While the American Medical Association has not admitted to intentional acts of racism with regard to the medical profession, it recently issued an apology for decades of racial division in medicine. Holly Watt, *Doctors' Group Issues Apology For Racism*, WASH. POST, July 10, 2008 *available at*

Ultimately, without firm precedent establishing that an infringement on reproductive health services constituted an equal protection violation that demands a standard of judicial review higher than rationale basis, midwives will likely not find success in raising equal protection claims in the courts.

iii. Due Process

The state police power – the capacity of the government and the states to regulate behavior for the betterment of the general welfare, and in furtherance of the positive development of the morals, health, and safety of their inhabitants – is general and broad. This is particularly true with regard to public health matters. In response to perceived over-regulation or restrictions on practice, midwives facing criminal charges or challenging restrictive statutes have raised due process claims and have challenged the limits of the state police power.

For example, the Professional Midwifery Practice Act[156] (PMPA) in New York required midwives to have a nursing degree and an established partnership with a local licensed physician. In *Leigh v. Board of Registration of Nursing* the court responded to a midwife's due process claim by determining that the statute was a valid exercise of the state's police power, and that the legislature had apparently concluded that midwives needed to have a specialized nursing degree.[157] The case serves as a clear example of the state's public health related police power and the judiciary's general deference to and recognition of that power.[158]

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http://www.washingtonpost.com/wp-dyn/content/article/2008/07/10/AR2008071001346.html?hpid=sec-nation.

[156] McKinney's Education Law, ch. 16, t. VIII, art. 140 (West).

[157] Leigh v. Bd. of Registration of Nursing, 395 Mass. 670 (1985).

[158] *See also* Sammon v. N.J. Bd. of Med. Examiners, 66 F.3d 639 (1995) (finding neither the due process rights of aspiring midwives nor those of women seeking to employ midwives were violated by a restrictive statute).

iv. Other Claims In The Courtroom

Midwives have raised a number of other claims while defending themselves against criminal charges or while challenging restrictive legislation. Statutes have been argued to be void for vagueness[159] and unconstitutional restraints on trade.[160] The claims are numerous and the successes incredibly infrequent. While claims against midwives are often settled outside of the courtroom, the numerous failures in the courtroom are illustrative of the difficulties midwives face when forced to defend themselves and their practice, or engage in litigation, and they suggest that solutions are likely to be found by engaging the state's police power in order create legislation that will allow CPMs to practice.

III. Expanding Access to Certified Professional Midwives

As a result of the limited legal protections available to Certified Professional Midwives (CPMs) in the courtrooms and through the use of the traditional reproductive rights jurisprudence, alternative venues need to be found in order to expand access to CPM services and ultimately make them available as an alternative to women who might otherwise be unable to find culturally competent care in a hospital setting. Legislative efforts at a state level have been an effective means of expanding access in those individual states. However, national legislation is needed in order to assure widespread access to CPM services and Medicaid funds for midwifery. In order to be successful on

[159] *See e.g.,* Bowland v. Municipal Ct. for Santa Cruz Co. Judicial Dist. 18 Cal. 3d. 479 (Cal. 1976) (responding to the statute was ambiguous and uncertain the court found that the statute was specific enough and only applied to people purported to be engaging in the healing arts); Dickerson v. Stuart 877 F.Supp. 1556 (M.D. Fla. 1995).
[160] *See e.g.,* Leigh v. Bd. of Registration in Nursing, 399 Mass. 558 (Mass. 1987) (finding that a statute requiring a licensing of midwives and requiring that CNMs practice only in licensed facilities did not create an illegal restraint of trade under federal or state law).

that plane, black CPMs and black midwifery organizations should be supported and the reproductive justice movement should be activated.

a. Legislation

State based legislation recognizing CPMs has been successful in over twenty-seven states[161] where CPMs can now practice legally. In those states, midwives and their supporters have partnered with medical associations that have historically been opposed to homebirth and they have educated the general public. However, those successes appear susceptible to challenge and suggest that the only way to assure that CPMs may continue to practice and provide their services on a broader basis is through national legislation and Medicaid coverage.

State-By-State

There have been several state-based legislative successes for recognition of CPMs. Legislative success, particularly in the recent past, has had a positive and substantial effect on the availability of CPMs. States continue to recognize the benefits of protecting CPMs by offering them legal recognition and making Medicaid funds available to them.[162] However, recent state statutes have not gone unchallenged, making clear that national recognition is necessary to ensure the widespread availability and cultural recognition of CPMs.

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[161] *See supra* note 108.

[162] For example, after licensing CPMs, the state of Virginia Department of Medical Assistance Services issued a memo informing all medical professionals in the state that CPMs would be enrolled in the state's Medicaid program. Memorandum from Patrick W. Finnerty, Director, Dep't of Med. Assistance Serv. to all Virginia Licensed Certified Professional Midwives, Medical Doctors, Nurse Practitioners, Nurse Midwives, Health Departments, Rural Health Clinics, Federally Qualified Health Centers, Laboratories, Outpatient Clinics, and Managed Care Organizations (MCOs) participating in the Virginia Medical Assistance Program (Oct. 11, 2007) *available at* http://commonwealthmidwives.org/files/10.11.07%20Medicaid%20Coverage%20of%20the%20Services%20of%20Certified%20Professional%20Midwives%20-%20FINAL.doc.

In April of 2009, Idaho became the twenty-sixth state to license CPMs.[163] The campaign behind the legislation noted that at least part of their success could be attributed to organized medicine's realization that with attention turned toward healthcare reform, coupled with the downturn in the economy, the demand for access to CPMs and safe homebirth would only grow.[164] The effort suggests that increased interest in making CPMs available may potentially motivate the medical industry to support legislation providing for regulatory oversight, transparency, accountability, and competency standards regarding CPMs.

However, not all medical organizations are supporting bills being proposed in the states.[165] In a 2008 case, the Missouri supreme court found that a medical association challenging the validity of a statute allowing CPMs to practice in the state[166] did not have standing to bring such a suit.[167] The majority declined to determine the constitutionality of the challenged statute, leaving it and the protection it provides to CPMs presently practicing in the state open to attack from other groups who may be able to successfully establish standing.[168] The two dissenting judges did take the opportunity to address the constitutionality of the statute and determined that the provision was, in fact, unconstitutional.[169]

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[163] 2009 Idaho Sess. Laws. Chap. 65. As of May 2010 those states that recognize CPMs include Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Idaho, Louisiana, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and Wyoming. In Rhode Island and New York only direct-entry midwives who are certified by the American Midwifery Certification Board (AMCB), are permitted to practice.

[164] Press Release, The Big Push For Midwives, Idaho Pushes Midwife Movement to the Tipping Point (April 1, 2009), *available at* http://www.thebigpushformidwives.org/_ccLib/downloads/2009-04-01_PushNews_RELEASE_Idaho_Pushes_Midwife_Movement_to_the_Tipping_Point.pdf.

[165] *Supra* notes 96 and 97.

[166] V.A.M.S. §§ 334.010, 376.1753

[167] Mo. State Med. Ass'n, et al. v. Mo. Midwives Ass'n, et al., 256 S.W.3d 85 at 87 (2008).

[168] *Id.*

[169] *Id.* at 91-92.

Although Idaho's previously mentioned success hinged on the support of major medical organizations, Missouri's own legislative recognition of CPMs hangs in the balance as the result of resistance from similar organizations. The Missouri case exemplifies the vulnerability of state regulations facing powerful medical organization that benefit from the monetary muscle and cultural acceptance that CPMs and their supporters typically lack.

States continue to debate the legality of midwives and the topic has become one up for public debate, even being taken on by state legislative candidates.[170] The arguments put forth range from ones centered around a right to privacy to the need for regulation and oversight in order ensure that those who are going to seek the care of midwives, regardless of the legality of the practice, will receive safe and competent care.[171] In any case, one thing is clear: the debate is alive and well, and doesn't appear to be going anywhere.[172]

Legislative victories have been coming fast in the past several years. Yet, it is not unlikely that states will see the medical profession and opponents or competitors of CPMs attempt to have statutes overturned based on issues of liability, competency, and public safety.[173] It appears that neither courtroom battles nor occasional state victories

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[170] *See* Travis Gulbrandson, *Health Care Debated by Area Candidates*, PRESS AND DAKOTA, (Oct. 30, 2010.) (reporting that South Dakota state legislative candidates took sides on that state's pending decision to license CPMs during a debate), *available at* http://www.yankton.net/articles/2010/10/30/community/doc4ccba23b5b27d372013403.txt.

[171] *Midwives, Mississippi Medical Community Spar Over Bill,* New England Cable News (Feb. 13, 2011), *available at* http://www.necn.com/02/13/11/Midwives-Miss-medical-community-spar-ove/landing_health.html.

[172] *See e.g.,* Holly Meyer *Midwife Legislation Receiving New Life,* Rapid City Journal (Feb. 12, 2011) (describing the re-introduction of legislation in South Dakota that would recognize and permit CPMs who register with the health department to practice) *available at* http://www.rapidcityjournal.com/news/article_b9c0ca88-3719-11e0-b753-001cc4c002e0.html;

[173] *See supra* notes 96 and 97, and accompanying text; AM. MED. ASS'N (AMA), RESOLUTION ON HOME DELIVERIES (April 28, 2008) (detailing the organizations belief that the only safe birth is a hospital birth) *available at* http://www.ama-assn.org/ama1/pub/upload/mm/471/205.doc; Press Release, American

will allow the care CPMs provide to have the profound effect that it is capable of having. So what remedies will help achieve that goal?

National Legislation

State-by-state campaigns should not be dismissed as anything less than vital to the continued and growing recognition of CPMs, particularly because they represent growing public support for the practice. However, congressional recognition could provide CPMs and patients with access to Medicaid funds, making the practice much more accessible to the communities that would benefit the most from its application. Such legislation could also ensure that competency and regulatory standards were applied evenly across the nation and eliminate or reduce the patchwork of regulation that exists today.

Over the course of the past three years a move toward national legislation and recognition has gained traction. The Big Push For Midwives[174] is a coordinated campaign that envisions a new model of U.S. maternity care built on expanding access to out-of-hospital maternity care and CPMs, who provide affordable, quality, community-based care that has been proven to reduce costly and preventable interventions as well as the rate of low-birth weight and premature births.[175] The campaign recognizes and emphasizes that CPMs "serve a disproportionate number of low-income, rural, immigrant and uninsured families" and that "regulation and licensure of CPMs ensures that there are

College of Obstetricians and Gynecologists (ACOG), ACOG Statement on Home Births (Feb. 6, 2008) (reiterating the organization's "long-standing opposition to home births), *available at* http://www.acog.org/from_home/publications/press_releases/nr02-06-08-2.cfm.

[174] The Big Push For Midwives | Access to Out-of-Hospital Birth, http://www.thebigpushformidwives.org/ (last visited Jan. 7, 2010).

[175] The Big Push: Pushing Today for CPMs, http://www.thebigpushformidwives.org/index.cfm/fuseaction/home.showpage/pageID/2/index.htm (last visited Jan. 7, 2010).

enough well-trained midwives to meet the demand for out-of-hospital birth and to provide safe and affordable maternity care for underserved populations."[176]

The stated mission of the Big Push for Midwives campaign is "to build winning, state-level advocacy campaigns towards successful regulation and licensure of CPMs in all fifty states, the District of Columbia, and Puerto Rico."[177] The campaign has seen several state-based successes since its inception, and gained even more footing when it had the opportunity to re-focus its efforts during the federal health care reform debate in 2009.[178] The campaign lobbied for CPM inclusion in the newly conceived of national health care plan, but were ultimately unsuccessful.

As discussed, state-by-state victories are nothing to be scoffed at. State recognition of CPMs will influence the discourse surrounding CPMs, and will undoubtedly strengthen the case for national recognition. While state statutes remain susceptible to challenge, the individual state-based campaigns will hopefully help create a nation-wide network of CPMs and homebirth advocates who can organize for national legislative recognition of the services CPMs provide. In doing so, the movement may be able to envelope and activate low-income women of color whose concerns have not been central to the concerns of the larger medical profession or the reproductive rights movement that helped create and sustain the privacy rights jurisprudence.

b. Movement Building

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[176] THE BIG PUSH FOR MIDWIVES, THE BENEFITS OF LICENSING CERTIFIED PROFESSIONAL MIDWIVES, *available a*t http://www.thebigpushformidwives.org/attachments/pages/Benefits+of+CPM+Licensure.pdf.
[177] THE BIG PUSH FOR MIDWIVES, HOW THE BIG PUSH FOR MIDWIVES CAMPAIGN IS MAKING THE DIFFERENCE, *available at* http://www.thebigpushformidwives.org/attachments/pages/How+the+Big+Push+Helps.pdf.
[178] *See Home-birth Advocates Push For Change In Laws*, ASS. PRESS, Jan. 28, 2009 (noting that the Big Push campaign initiated an email campaign directed toward President Barack Obama that advocated for the inclusion of CPMs in healthcare reform) *available at* http://www.msnbc.msn.com/id/28901624/wid/21370087/.

In order to ensure not only an increase in legislative protections for CPMs but also expanded knowledge about and access to the care they might provide in low-income communities of color, black CPMs and midwifery organizations should be acknowledged and supported. Additionally, advocates should partner with activists in the reproductive justice movement, which developed in the wake of the overwhelmingly white and middle-class reproductive rights movement, in order to ensure that the actual needs, rather than the perceived needs of low-income women of color are being met.

Black Midwives

Midwifery supporters seeking to expand CPM access in communities of color should defer to midwifery associations and organizations led by women of color[179] that are tackling the issue of access to midwives and alternative forms of health care. It is true that the homebirth movement as it presently exists has been primarily white and middle class, and as such many professional midwifery organization and educational institutions reflect and are branded to attract those demographics. On paper and in practice, the care CPMs offer provides innumerable benefits to low-income women of color who have long been disenfranchised and excluded from the medical industry, but in order to best meet the needs of those communities organizations and training centers that are run by and inclusive of women of color should be emphasized, supported, and consulted.

Reproductive Justice

Despite the many legislative, legal, and policy restrictions that they face, CPMs have been recognized and affirmed in some courtrooms, and by some legislatures. While

[179] The International Center for Traditional Childbearing is almost undoubtedly the most well known of these organizations. ICTC Midwives, http://www.ictcmidwives.org/ (last visited Feb. 26, 2011).

such successes are important, even imperative to the continuation of the profession, they should not be the only focus of advocates. By emphasizing the inclusion of the underrepresented women they seek to serve, CPMs and their advocates may impact the shape and framework of the way women conceive of reproductive rights and their own autonomy. Activating low income women of color through CPMs and the reproductive justice movement may help move reproductive health jurisprudence away from a privacy-based constitutional framework, and toward a social justice oriented, culturally sensitive, and holistic approach to understanding women's health.

The reproductive rights movement has been criticized for its failure to recognize and focus on those issues of reproductive health and autonomy that exist outside the narrow sphere of abortion rights. "The focus of reproductive rights discourse on abortion rights neglects [the] broader range of reproductive health issue . . . . If abortion is at the heart of women's reproductive rights, then state policies that do not interfere with that right seem acceptable."[180] Instead, Reproductive Justice incorporates abortion rights with other issues low-income women of color faced.[181] The reproductive justice movement seeks to expand the "the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights" and to include women typically excluded by the reproductive rights movement's choice and privacy oriented focus.[182] The movement points out that as indigenous women and women of color, it is important to fight equally for the rights to have or not have children, and the right to parent and control birthing options as it is to

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[180] DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION AND THE MEANING OF LIBERTY 300-01 (Pantheon Books, ed., 1997).
[181] Loretta Ross, *What is Reproductive Justice?*, *in* REPRODUCTIVE JUSTICE BRIEFING BOOK 4, *available at* http://www.protectchoice.org/downloads/Reproductive%20Justice%C20Briefing%20Book.pdf.
[182] *Id.*

fight for the right to abortion.[183] CPMs and their supporters may benefit from adhering to a reproductive justice, rather than a reproductive rights framework when discussing their practice with those who are oppose to it.

Women of color have largely led the reproductive justice movement by connecting social justice issues with reproductive health. By ensuring that the established reproductive justice movement is made an integral part of the campaign for widespread access to CPMs, not only will the voice of the campaign be given an air of authenticity, but also it will ensure that the actual needs, rather than the *perceived* needs of low-income women of color are being met.

Conclusion

The history of midwifery tells an important story. It is a story that acknowledges, as it must, the racism and disparate treatment of communities of color in the United States and the continuing effects of that treatment. Specifically, it highlights the medical profession's different treatment of black midwives and the ways in which it has prevented all women from reaping the benefits of the unique and holistic maternity care offered wholly outside of the medical profession by Certified Professional Midwives.

Certified Professional Midwives and their struggles in the courtroom also instruct us on the limitations of the right to privacy that developed out of the reproductive rights jurisprudence following *Roe v. Wade*, and suggest that it is time to reconsider how reproductive rights are defined, and how we might make them more expansive to include those who have been historically excluded from their benefit and protection. In this context, that includes not only pregnant and birthing women, but more importantly and more generally, low-income women of color.

[183] *Id.*

The Midwifery Model of Care offers continuous, holistic, and culturally sensitive care that may be uniquely beneficial to low-income women of color who might otherwise have only limited access to health care. However, in order to ensure that CPMs become more widely available, homebirth advocates and CPM supporters must not only continue to advocate for state-based legislative recognition and licensure of CPMs, but also for national legislation and greater cultural acceptance of this alternative form of healthcare. By specifically seeking guidance and support from black midwives and the reproductive justice movement CPMs and their advocates can help to ensure that the advantages of the Midwifery Model will reach those women it has the most potential of impacting.