Articles

The Fight for Birth: The Economic Competition that Determines Birth Options in the United States

By Jessica Brown*

“[T]he way that birth care is organized and carried out will have a powerful effect on any human society.”

Introduction

The United States has the most expensive maternal and infant care system in the world, yet it also has the highest rate of maternal and infant mortality of any wealthy country. This paradox is a direct result of the economics of birth care. The piecemeal nature of services paid for by insurance, the culture of patient acquiescence to obstetric expertise, and a system that requires litigation to address substandard care all contribute to an expensive system with poor health outcomes. The homebirth midwifery model, though used in less than

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one percent of all births, is an alternative to the obstetric model and it is highly controversial. But is it safer?

Evidence from other developed countries suggest that midwife-assisted childbirth—both in the hospital and at home—is safe and cost-effective. In the United States, however, conditions for childbirth are determined in a marketplace that includes for-profit hospitals and clinics. The vastly different approach to childbirth that exists between these countries poses the question of which policies and regulations create the best available option—private hospitals and birthing centers, public hospitals and clinics, or home births?

To address these questions, this Article analyzes the history of the state regulation of midwifery as well as legal and policy challenges to these regulations. I begin by discussing the history of midwifery and the current state of midwifery in the United States. I go on to examine litigation initiated by midwives against statutory limitations and licensing requirements under theories of substantive due process, the right to privacy, and conspiracy in restraint of trade. Then, I explore disparate policy and state regulations—or lack of regulations—for midwives, and how those policies affect consumers. Finally, I offer recommendations for new state regulations.

Background

“Remember this, for it is as true as true gets: Your body is not a lemon. You are not a machine. The Creator is not a careless mechanic. Human female bodies have the same potential to give birth well as aardvarks, lions, rhinoceri, elephants, moose, and water buffalo. Even if it has not been your habit throughout your life so far, I recommend that you learn to think positively about your body.”

A Brief History of Obstetrics and Midwifery

Before the 1930s, childbirth was not considered a medical event, and American women gave birth almost exclusively at home. From
the colonial period to the mid-nineteenth century, midwives provided pregnancy, labor, and postpartum care using traditional European practices.\(^8\) But as physician-assisted birth gained popularity among affluent European women, their counterparts in the United States increasingly sought physician-assisted birth at home.\(^9\) Because of the increasing popularity of physician-assisted birth, the American Medical Association (AMA) recognized obstetrics as a specialty practice area in 1859, and the AMA lobbied legislatures to pass laws that required licensure for the practice of obstetrics.\(^10\) Nonetheless, general practitioners, not obstetricians, assisted most births (when physicians were involved at all) prior to the 1930s.\(^11\)

In 1900, less than five percent of women in the United States gave birth in hospitals.\(^12\) Most maternity hospitals were urban charitable organizations for poor, homeless, or working class married women who might not have had homes in which to deliver.\(^13\) Not coincidentally, maternal mortality rates were lowest when women gave birth at home with trained midwives rather than in hospitals.\(^14\) Due to inadequate hygiene practices in hospitals, doctors routinely infected birthing mothers with diseases to which women would not have normally been exposed at home.\(^15\) For example, mothers who gave birth in these hospitals frequently died of puerperal fever.\(^16\)

By the 1930s physicians such as J. Whitridge Williams, Professor of Obstetrics at Johns Hopkins University, recommended that women give birth in hospitals.\(^17\) He urged mothers to go to hospitals so that medical students who specialized in obstetrics could increase their understanding of obstetric science and skills.\(^18\) Williams also claimed that women would receive better care in hospitals.\(^19\) By 1935, only five

\(^8\) Judith Pence Rooks, Midwifery and Childbirth in America 17–26 (1997).
\(^9\) Id. at 21.
\(^10\) Id.
\(^11\) Wertz & Wertz, supra note 3, at 147.
\(^13\) Id.
\(^14\) Loudon, supra note 7, at 242S.
\(^16\) Id.
\(^17\) Wertz & Wertz, supra note 3, at 146–47.
\(^18\) Id.
\(^19\) Id. at 147.
percent of women gave birth assisted by midwives, though fifty-four percent of births to black mothers were assisted by midwives.20

Due to the advent of rudimentary advances in medicine and other conventions at the time, hospitals became more desirable places to give birth.21 The use of penicillin and pain-relieving medications made them safer and more pleasant.22 Additionally, the convention of the time was to ascribe the deaths of women attended by midwives to the attending midwives, though obstetricians were not similarly treated as liable when their patients died.23 By 1953, only three percent of white women, and twenty percent of black women gave birth assisted by midwives.24 Midwifery and home birth remained common in the United States only in regions characterized by high degrees of poverty and low-education, notably the South.25 By the 1960s, doctors had a virtual monopoly on maternity care.26

Contemporary Care Practices and Critiques of Those Practices

In hospitals, maternity care became more medicalized and standardized.27 Data from the past ten years indicates that, in the United States, doctors induce approximately twenty-three percent of labors,28 almost one-third of all labors end in cesarean section, and seventy-one percent of women receive epidural blocks during childbirth.29 Ninety-two percent of women give birth in the supine position, or slightly elevated supine position, for the doctor’s convenience, though medical studies suggest the best way to give birth is by squatting.30 In fact,

21. Id. at 26.
22. Id.
23. Id. at 23.
24. Id. at 24.
25. Id.
26. Id.
27. Id. at 26.
epidurals combined with pushing in a supine position are associated with an increased risk of episiotomies, vacuum and forcep-assisted deliveries, fetal heart rate abnormalities, second-degree tears, and blood loss.\textsuperscript{31}

Starting in the late 1960s and early 1970s, feminists and Christian religious communities became vocal critics of medicalized childbirth.\textsuperscript{32} Their critiques occurred in tandem while advocating for a wider range of birthing options—including midwife assisted births.\textsuperscript{33} Feminists such as Pamela Klassen encouraged women to reject obstetric births by exercising their “consumer power.”\textsuperscript{34} In other words, women should stop paying for piecemeal care in hospitals and pay for midwifery care instead. Other feminists argued that a movement based on consumer power relegates poor women who are disproportionately women of color to hospitals because midwifery care is not covered by private or public insurance.\textsuperscript{35} As a result of this movement, homebirth midwifery still remains an option mostly for white, middle-class women.\textsuperscript{36}

Today, the midwifery landscape in the United States is a tangle of competing scientific studies, competing economic interests, litigation, state licensing, and state regulations. Within that tangle are women and babies. The following section details the state of midwifery today, and explores ways in which individual states can move toward a more woman- and infant-centered approach rather than an “industry” approach.

**The United States and the Rest of the World**

In the United States, childbirth is an *industry*, but in most countries around the world childbirth is a part of an overall healthcare *system*. In the United States, obstetricians—who are trained surgeons—provide most prenatal care; they do so in a piecemeal, or a la carte, fashion in which each visit to the doctor is treated as a discrete encounter and billed to insurance companies as such.\textsuperscript{37} Additionally, obstetricians attend the vast majority of births.\textsuperscript{38} Because the United

\textsuperscript{31.} Id.
\textsuperscript{32.} Christa Craven, Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement 3 (2010).
\textsuperscript{33.} Id.
\textsuperscript{34.} Id.
\textsuperscript{35.} Id.
\textsuperscript{36.} Id.
\textsuperscript{37.} Rosenthal, supra note 2.
\textsuperscript{38.} Id.
States has an a la carte maternity care system in which trained surgeons care for low risk women, fully one-fifth of all health care expenditures in the United States are spent on maternity.39 Prenatal, childbirth, and newborn care make up a $111 billion dollar industry.40 However, the United States has the highest maternal mortality rate among industrialized countries.41 The United States ranks sixtieth in the world overall in maternal mortality deaths, which is below all other developed nations.42 Our maternal mortality rate is triple that of the United Kingdom, and eight times that of the world’s leader, Iceland.43 In most other developed countries, every woman has access to free or low-cost prenatal care.44 In the United States, however, a significant portion of women cannot afford prenatal care that would keep them and their babies healthy.45 Amnesty International reports:

[w]omen, above all women on low incomes, can face considerable obstacles in obtaining maternal health care, particularly in rural and inner-city areas [in the United States]. Doctors may be unwilling or unable to provide maternal health care because of the high costs and low fees involved[,] or because of cumbersome reimbursement procedures via Medicaid.46

By contrast, seventy-percent of European women give birth assisted by midwives in hospital settings.47 For low-risk pregnancies, midwives are the only caregivers European women see throughout

42. Id.
43. Id.
44. Id.
45. Id.
47. Sarah Anne Stover, Born by the Woman, Caught by the Midwife: The Case for Legalizing Direct-Entry Midwifery in All Fifty States, 21 HEALTH MATRIX 307, 332 (2011).
pregnancy, labor, and birth. All European countries have lower infant and maternal mortality rates than the United States.

In the United Kingdom, the National Health Service is state run and not-for-profit. Women pay nothing for medical care and doctors are paid on a scale set by the state. Doctors and midwives routinely collaborate in hospital settings and in the provision of home-birth care because economic competition is not a factor. In fact, midwives lead care in the U.K. at more than half of all births. “Every mother deserves a midwife, and some need an obstetrician, too,” is a common refrain there.

Unlike the recommendation by the American College of Obstetricians and Gynecologists (ACOG) for women to give birth in hospitals attended by obstetricians, guidelines issued in 2014 by the U.K.’s National Institute for Health and Care Excellence (NICE) recommend that women with low-risk pregnancies stay at home to give birth or give birth in midwife-led hospital units. According to the NICE report, “evidence now shows midwife-led units to be safer than hospital[s] for women having a straightforward (low risk) pregnancy,” and “[r]esearch also shows that a home birth is generally safer than hospital[s] for pregnant women at low risk of complications who have given birth before.”

Like the U.K., the Netherlands has a medical structure that incorporates midwives in the interest of economic efficiency—and also because Dutch women prefer home births. The Netherlands regulates access to specialty obstetric care through primary and secondary refer-

48. Id.
49. Id.
53. Cruz, supra note 5.
54. Id.
56. Id.
Women with low-risk pregnancies rarely move from primary midwifery care to secondary obstetric care during pregnancy because midwifery care is sufficient for uncomplicated pregnancies, and because Dutch women prefer midwifery care.58

Like the U.K., the Netherlands has low maternal and fetal mortality rates, though forty percent of Dutch women give birth without obstetric assistance.59 One-third of Dutch women give birth at home, and an additional ten percent give birth in hospitals with midwives.60 Yet their neonatal and maternal outcomes are some of the best in the world.61 The Netherlands has a 0.002% neonatal mortality rate, and a 0.007% maternal mortality rate.62

In the United States, nearly all women give birth in hospitals, yet our birthing outcomes are abysmal relative to Europe’s. Four million babies are born each year in the U.S.,63 and 98.64% of those births take place in hospitals.64 Although out-of-hospital births, both planned and unplanned, made up only 1.36% of all births in the U.S in 2012,65 the neonatal and maternal mortality rates in the U.S. for that year were double those of the Netherlands—0.004%, and 0.014%, respectively.66

The ACOG argues that women are fundamentally different in the United States compared to the Netherlands, or the U.K.67 It cites high levels of obesity, late maternal age, and lack of consistent prenatal care as reasons American women should continue to give birth in hospitals with obstetricians in attendance.68 However, Neel Shah, professor of obstetrics at Harvard Medical School, argues in the New England

58. Id.
59. Id.
60. Id.
62. Id.
63. Rosenthal, supra note 2.
65. Id.
66. Id.
68. Id.
**Journal of Medicine** that the evidence from the United Kingdom regarding midwifery care is compelling.\(^{69}\)

Obstetricians, who are trained to use scalpels and are surrounded by operating rooms, are much more likely than midwives to pick up those scalpels and use them.\(^{70}\) For women giving birth, the many interventions that have become commonplace during childbirth are unpleasant and may lead to complications, including hospital-acquired infections.\(^{71}\) For babies, the interventions rarely appear to be helpful.\(^{72}\)

Shah’s conclusion parallels and supports arguments midwives have made for years: over-medicalization harms women and babies. Indeed, the World Health Organization recommends that a country’s cesarean section rate stay below fifteen percent of all births because a rate higher than fifteen percent is not associated with better maternal or neonatal mortality rates.\(^{73}\)

What forces drive the United States to maintain a health care industry that is more expensive yet has poorer outcomes than those evident throughout Europe? In contrast to Europe, whose system focuses more on the patients’ physical and financial health, the U.S. maintains a system that is largely driven by the hospital industry.

### Cesarean Section Rates in the United States

The United States healthcare system features much more frequent recourse to cesarean sections than other nations. According to the Centers for Disease Control, the U.S. has a 32.2% cesarean section

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\(^{70}\) Id. (citation omitted).

\(^{71}\) Id.

\(^{72}\) Id.

\(^{73}\) World Health Org., *WHO Statement on Cesarean Section Rates*, [http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1) (last visited Sept. 4, 2017) [https://perma.cc/35K2-3EYE]. WHO stated that “[b]ased on the WHO systematic review, increases in caesarean section rates up to 10–15% at the population level are associated with decreases in maternal, neonatal[,] and infant mortality. Above this level, increasing the rate of caesarean section is no longer associated with reduced mortality. However, the association between higher rates of caesarean section and lower mortality weakened or even disappeared in studies that controlled for socioeconomic factors. Since it is likely that socioeconomic factors can explain most of the association between increased caesarean section rates and lower mortality in this review, WHO conducted another study to further analyse this aspect.” Id. at 3 (citation omitted).
rate,\textsuperscript{74} and researchers estimate that half of American C-sections are performed unnecessarily.\textsuperscript{75} In fact, a woman’s chance of having a cesarean section may increase depending on the hospital in which she chooses to give birth rather than the nature of her labor.\textsuperscript{76} Consumer Reports investigated 1,300 hospitals in the United States and found that “C-section rates for low-risk deliveries [among U.S. hospitals] vary dramatically,” even in the same communities and among similar institutions, and that in most hospitals the rates are above national targets.\textsuperscript{77} The U.S. is home to 216 hospitals with C-section rates above 33.3% for low-risk pregnancies.\textsuperscript{78}

The over-use of C-sections results in poor health outcomes for mothers. The risks involved in these surgeries are significant. Unnecessary C-sections may cause 20,000 complications a year, including sepsis and hemorrhage.\textsuperscript{79} Shah argues the reason for the high number of C-sections in the country is the result of inductions for the convenience of hospital staff.\textsuperscript{80} Of course, C-sections are generally more lucrative for hospitals and doctors than vaginal births.\textsuperscript{81} In a report released by the National Bureau of Economic Research, researchers concluded that “[o]bstetricians perform more cesarean sections when there are financial incentives to do so.”\textsuperscript{82} Interestingly, the researchers also found, based on data from hospitals in California and Texas, that doctors themselves are ten percent less likely to get C-sections, suggesting that obstetricians may treat physicians differently than other patients, or physicians who are patients are more willing to refuse unnecessary procedures.\textsuperscript{83}


\textsuperscript{75} Tara Haelle, Your Biggest C-Section Risk May be Your Hospital, CONSUMER REPORTS (May 16, 2017), http://www.consumerreports.org/doctors-hospitals/your-biggest-c-section-risk-may-be-your-hospital/ [https://perma.cc/7DL9-R22M].

\textsuperscript{76} Id.

\textsuperscript{77} Id.

\textsuperscript{78} Id.

\textsuperscript{79} Id.

\textsuperscript{80} Id.


\textsuperscript{82} Id.

\textsuperscript{83} Id.
Midwifery Today

Several kinds of midwives practice in the United States today. Direct-Entry Midwives (DEM’s) and Traditional Midwives attend homebirths but eschew licensing. No standards for training or education exist for DEMs and Traditional Midwives. Three other types of midwives are all credentialed—Certified Midwives (CMs), Certified Nurse Midwives (CNMs), and Certified Professional Midwives (CPMs). Qualifying as a CNM or CM requires a graduate degree in nursing or at least a master’s degree in a field of science or medicine.

Midwives who wish to be licensed as CNMs or CMs must acquire clinical experience and sit for certification examinations. All fifty states plus the District of Columbia recognize CNM licenses. New Jersey, New York, Rhode Island, Delaware and Missouri also recognize CM licenses. Ninety-seven percent of CMs and CNMs practice in hospitals. CPMs, on the other hand, do not need to have college degrees, and they primarily assist with home births. For certification, the North American Registry of Midwives requires a Portfolio Evaluation Process, or completion of a program approved by the Midwifery Education Accreditation Council, or completion of a state licensure program. Twenty-eight states regulate CPMs.

Concerns About Home Birth In the United States

A small percentage of American women have turned to home birth as an alternative to the over medicalization of hospital birth, but the safety of home births in the United States is not clear. Amy Tuteur, an obstetrician, argues that home birth in the U.S. is more dangerous than hospital birth because, unlike in Europe, home birth...
midwives in the U.S. are not adequately trained, and take more risks than midwives in other countries.95

CPMs are often educated through correspondence courses and apprenticeships; therefore, Tuteur claims, CPMs are not properly trained to prevent, diagnose and manage complications—the one thing trained attendants are supposed to do.96 Additionally, Tueter writes, CPMs take unnecessary risks by attending complicated births such as breech births or births involving twins.97 In contrast, when women in Canada and the Netherlands face these kinds of complications they are required to go to the hospital.98 Tuteur also points to statistics gathered in Oregon, one of the first states to track home-birth midwifery.99 In Oregon in 2012, fetal demise occurred in sixty-two births.100 Fifty-eight of these cases occurred in hospitals (out of 39,990 hospital births); four fetal demise cases happened at home (out of 2,021 home births).101

Tutuer notes that while the fetal death rate in Oregon home births is seven times that of the death rate for hospital births, the numbers are so small on home births that no statistical significance to them can be assigned.102 Oregon’s health department prefaces the statistics with information about pre-natal care. According to the health department, “[w]omen who planned out-of-hospital births compared to women who planned in-hospital births were more likely to have no prenatal care (2.8% vs. 0.4%) or inadequate prenatal care (9.8% vs. 4.8%), and less likely to begin prenatal care in the first trimester (63.6% vs. 76.6%).”103 These numbers may be the result of one or several factors including poverty and lack of maternal education. Without further research, the reasons for poor home birth outcomes in Oregon will continue to be unclear.

96. Id.
97. Id.
98. Id.
99. Id.
101. Id.
102. Tuteur, supra note 95.
Birth Centers as an Alternative to Market Imbalances

Why, then, is the current maternity care marketplace in the United States so seemingly inefficient, allocating significant share of resources to hospital births despite evidence of better outcomes (lower mortality rates) from home births in Europe? One midwife answered this question by noting the economic interests of the maternity industry:

I almost feel like there is another hand that is pushing for the high-cost of obstetrics . . . . That is not good for mothers, babies, or midwives. But it is good for physicians and hospitals and drug companies.

What midwives do is . . . not billable. [Midwives] would rather not use IVs, fetal monitors, and medications. What the hospital looks at is ‘What is this going to get us in billables?’ [the economic interests are obvious and mischievous; but the question is, what is it about the legal framework that steers women into hospitals?]

Steffie Goodman also makes the argument that economic interests lead to limited options for women to have midwife-facilitated childbirth. She writes, “the health care needs of the woman and the financial needs of the midwife are secondary to the economic needs of the physician or institution.” She cites a case in which doctors at a university hospital retaliated against midwives for an auditor’s whistleblowing. The auditors discovered fraud by obstetricians who were billing Medicaid for births attended by midwives. The FBI and the state brought a suit that resulted in a $5.1 million settlement paid by the hospital. Just a few months later, physicians at the hospital determined that the population the hospital served was too high-risk, and thus inappropriate for midwifery care. Yet, the state’s demographic data showed no change in risk characteristics. Despite repeated requests for information from the hospital for evidence regarding its actions, the hospital provided no evidence.

Obstetricians possess considerable political and social power. ACOG has a Political Action Committee that lobbies Congress, as well

104. Goodman, supra note 39, at 617.
105. Id.
106. Id. at 616.
107. Id.
108. Id.
109. Id.
110. Id.
111. Id.
112. Id.
as having state PACs that lobby every state legislature. For this reason, health care in the United States "does not conform to traditional economic theories in the same way as non-health-related markets because of issues relating to information, authority, power, wealth, and control." Health consumers are not necessarily well-informed. As a result, health care providers can, and have, distorted healthcare policy to benefit doctors rather than consumers.

In addition to political power, obstetricians maintain considerable social power as well. Often labor and delivery nurses find that they cannot serve as advocates on behalf of patients who want to prevent or delay unnecessary cesarean sections when doctors intend to perform them. Medical anthropologist Brigitte Jordan observes: "The power of authoritative knowledge is not that it is correct but that it counts." Sociologist Paul Starr also argues that professionals become powerful when social and cultural factors require patients to surrender to professionals’ judgment. Compounding the power differential is the fact that health care consumers are usually dependent, vulnerable, and inadequately informed.

Thus, power differentials within the maternity care sector perpetuate market conditions that, according to the statistics on maternal and infant outcomes, prioritize the economic needs of doctors over the health of mothers and babies. This problem can be resolved through better commercial regulation that allows mothers and mid-

115. See id.
116. Christine H. Morton, Preventing Cesarean Delivery: What is the Nurses Role?, Sci. & Sensibility, https://www.scienceandsensibility.org/p/bl/et/blogid=2&blogaid=542 [https://perma.cc/R9C5-6UU7] (“I believe when nurses speak about cesareans they are not only focused on unplanned, intrapartum cesareans but also scheduled cesareans or scheduled inductions, which can result in a cesarean. It was clear from the interviews that nurses felt less invested in the decision-making process when women came in for scheduled cesareans or planned inductions. Nurses also spoke of how women are set up for failure during pregnancy—by way of unfavorable media messages, lack of unbiased childbirth education, and lack of risk reduction information from prenatal care providers.”).
wives to use facilities other than hospitals or homes. In a 2014 report prepared for the Federal Trade Commission, the American Association of Birth Centers (AABC) alleged that because hospitals and obstetricians are legally secured they have a significant advantage over midwives in the U.S. marketplace.\footnote{120 FTC, supra note 40, at 8.}

The AABC proposed that a more efficient and otherwise better care alternative would be to expand the market share occupied by birth centers. A birth center is a facility that is not in a hospital. In a birth center, midwives provide prenatal, postpartum, well-woman, and newborn care.\footnote{121 Id. at 2.} Some centers feature managing obstetricians to whom midwives refer patients who need surgical or advanced medical care. Midwives own other birth centers, and patients who need physicians’ services are transported to hospitals from these centers as needed. The AABC argued that birth centers have been limited in their penetration of the maternity care marketplace due to the following factors:

(1) Regulatory schemes present significant “barriers to entry or otherwise restrict the ability of birth centers and midwives to compete in the maternity services market;”

(2) Hospitals and physical groups are organized and perhaps concerted in their efforts to oppose birthing centers;

(3) Independent Practice Associations (IPA’s), Health Maintenance Organizations (HMO’s) and the Accountable Care Organization (ACO), excluded birth centers and midwives from participating in their managed care provider panels.\footnote{122 Id. at 8–9.}

Additionally, hospitals are often in direct competition with birthing centers, and are, therefore, unwilling to enter into transfer or transport agreements with birthing centers even when those agreements would “improve patient care by providing for more seamless transfers.”\footnote{123 Id. at 12.}

There is a clear demand by mothers for birth centers as alternatives to hospitals. According to a New Mothers Speak Out Survey, thirty-nine percent of respondents indicated that they would consider giving birth in a birthing center, and a whopping twenty-five percent stated they would “definitely” want to use a freestanding birth center.\footnote{124 Eugene R. Declercq et al., Pregnancy and Birth, LISTENING TO MOTHERS III SURVEY (Childbirth Connection, New York, N.Y.), May 2013, http://transform.childbirthconnexion} However, the regulations noted above deter women from
taking advantage of the birth-center option in many regional markets. Without such regulations, midwives practicing in birthing centers could meet these women’s needs by offering low-cost alternatives to physician-assisted birth—alternatives which, the data show, yield better outcomes than physician assisted births. On this basis, some researchers contend that current public health policies produce inequitable access to health care for women giving birth in the United States by reducing access to low-cost, effective birthing care in favor of more costly, less effective care.

Rights, Litigation, and Prosecution

“One of the downfalls of our excessively comfortable society is the idea that pain is a bad thing to be avoided at all costs . . . A self-possessed woman in childbirth can be a powerful teacher for all (including herself) on the temporality, humility, and connectedness of life. What if the medical establishment that purports to be saving women from the specter of pain and danger is instead ejecting them from the seat of their power?”

The Right to Have a Midwife-Assisted Birth

The United States Supreme Court has not ruled on whether a woman has a fundamental right to have a midwife or homebirth, and whether a woman has the right to control her birth at all varies among the states. Griswold v. Connecticut and Roe v. Wade established a woman’s right to privacy with regards to controlling reproduction, but it is not clear whether the right to privacy extends to a woman’s choices regarding birth. Several courts have held a mother cannot refuse medical treatment when her fetus is in distress during birth. In Maryland in 1996, a pregnant woman challenged a statute that barred Direct Entry Midwives from practicing. She argued that the right to a midwife assisted birth was a fundamental right. The court, citing Roe v. Wade, held that the fundamental right to privacy does not include the right to determine how one gives birth. Thus, the statute

125. Goodman, supra note 39.
126. Id.
127. Id.
129. 381 U.S. 479 (1965).
130. 410 U.S. 113 (1973).
132. Id.
received rational basis review. Because the health and welfare of the mother and infant were a legitimate state interest, a ban on DEMs did not violate privacy rights.

Similarly, a Florida judge ordered a woman to undergo a cesarean section after she labored for two days at home unsuccessfully in 1999. The woman went into the hospital seeking fluids, but fled the hospital when doctors deemed a cesarean section necessary. The court held that the “scope of Ms. Pemberton’s personal constitutional rights in this situation . . . did not outweigh the interests of the State of Florida in preserving the life of the unborn child.”

On the other hand, an appellate court in the District of Columbia held that a mother who was dying of cancer had the right to decide for herself whether to have a cesarean section. The lower court granted permission to her doctors to perform a cesarean on the dying woman. However, the child died shortly after the operation, as did the mother. An appeals court later reversed the lower court’s decision, stating that the woman had a right to decide for herself whether to have the operation, and that the state was not entitled to demand that she undergo a cesarean.

The Right to Be a Midwife

A separate issue is whether midwives themselves have the right to practice. Home birth midwives and Nurse Midwives who practice in hospitals have brought suits in two distinct contexts. First, home birth midwives and prospective parents have challenged statutes barring home births. These unsuccessful suits alleged that the statutes in question violated the midwives’ fundamental rights to privacy and due process. The second context includes suits by midwives under antitrust theories. A Sixth Circuit court reversed summary judgment on a claim brought by nurse midwives who alleged that obstetricians conspired to exclude them from practicing in local hospitals. Thus, while home birth midwifery may not be a constitutionally protected fundamental

133. Id. at 975–76.
134. Id. at 976.
136. Id.
137. Id. at 1251.
139. Id. at 1252.
140. Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605, 607 (6th Cir. 1990), opinion modified on reh’g, 927 F.2d 904 (6th Cir. 1991).
right, nurse midwives have at least been successful when alleging a conspiracy to exclude midwifery in hospitals.

Midwifery-Assisted Birth as a Fundamental Right

In the Second and Third Circuits, midwives and prospective parents brought suits challenging state statutes that prevented midwives from providing home birth services. Both Circuits held that no fundamental right to a home birth existed under due process or right to privacy arguments. Therefore, they held, that the ability to select a health provider of choice to assist with birth was not a fundamental right and states can regulate homebirth accordingly.141

In Lange-Kessler v. Dep’t of Educ. of the State of N.Y, Direct Entry Midwives challenged a New Jersey law prohibiting DEMs from practicing home births.142 The midwives alleged that the law unconstitutionally deprived them of their property interest in practicing their profession, a right protected by due process enumerated in the Fifth and Fourteenth amendments.143 But, under current law, a state needs only a rational basis to restrict the right to practice a profession.144 The Second Circuit found that the New Jersey legislature had an identified interest in “protecting the health and welfare of mothers and infants, and thus, New Jersey’s regulation of midwives did not violate the DEMs’ due process rights.145

The court in Lange-Kessler also held that the legislation at issue did not violate the DEMs’ right to privacy.146 In making this decision the court relied on Connecticut v. Menillo.147 In Menillo, the Connecticut Supreme Court upheld a state statute that required abortions to be performed by physicians because decisions regarding a pregnant mother’s healthcare provider do not fall within the right to privacy guaranteed in the Constitution.148 The court wrote: “In the abortion context, the Supreme Court has not interpreted the right to privacy so broadly that it encompasses the right to choose a particular healthcare provider.”149

141. See generally 109 F.3d 137, 139 (2d Cir. 1997), and 66 F.3d 639, 640 (3d Cir. 1995), for a discussion on why no fundamental right to a homebirth exists.
142. 109 F.3d 137, 139 (2d Cir. 1997).
143. Id. at 140–42.
144. Id.
145. Id. at 140.
146. Id. at 141–42.
147. Id. (relying on Connecticut v. Menillo, 423 U.S. 9 (1975)).
148. Id.
149. Id. at 141.
Similarly, in Sammon v. New Jersey Board of Medical Examiners, DEMs brought a suit challenging their right to practice under a theory of substantive due process.150 The Third Circuit held that New York’s law barring DEMs from practicing home birth midwifery was rationally related to the state’s interest in protecting mothers and infants.151 Thus, no fundamental right to a midwife assisted birth existed.152

Antitrust Actions against Obstetricians Brought by Midwives

The Sixth Circuit, in Nurse Midwifery Associates v. Hibbett, offers an illuminating glimpse into the economic competition between obstetricians and midwives.153 In 1990, the Sixth Circuit reversed a grant of summary judgment in favor of defendant obstetricians and insurers entered by a lower court.154 Two nurse midwives brought an antitrust action against practicing obstetricians in three Nashville hospitals and a physician-controlled insurance company applying the Intracorporate Conspiracy Doctrine.155 The claim alleged that obstetricians and insurers conspired to exclude midwives from hospitals.156 A lower court granted summary judgment on multiple antitrust claims, and the Sixth Circuit reversed in part and remanded.157

The lower court maintained that “[t]he crux of the complaint is that the defendant physicians, in order to protect their lucrative obstetrics practices in Nashville, Tennessee, sought to prevent the nurse midwives from competing with them.”158 The nurse midwives had applied for practicing privileges in three Nashville hospitals, including Vanderbilt University Hospital, and after initial positive responses from the hospital, obstetricians voted to bar the midwives.159 Prior to making this decision the obstetricians failed to inquire into the practice of the midwives. The obstetricians did not appear to be interested in the manner in which the nurse-midwives practiced during interviews with the midwives nor when the doctors reviewed the midwives’ applications for hospital admitting privileges.160 The plaintiffs in the

150. 66 F.3d 639, 640 (3d Cir. 1995).
151. Id. at 645–46.
152. Id. at 645.
153. 918 F.2d 605, 607–08 (6th Cir. 1990), opinion modified on reh’g, 927 F.2d 904 (6th Cir. 1991).
154. Id. at 617.
155. Id. at 607–08.
156. Id.
157. Id. at 617.
158. Id. at 607–08.
159. Id. at 608.
160. Id. at 608–09.
case were given an opportunity to discuss their protocol with an ad
dhoc admitting committee at one of the hospitals; however, the doctors
were again not interested in hearing about the midwives’ protocols
and only expressed concern with the financial relationship between
the midwives and the doctor who supported their bids.161

Obstetricians responded to the midwives’ petitions for hospital
privileges by threatening to adopt new policies that precluded stan-
dard midwifery practices and burdened laboring women.162 After the
obstetricians barred the midwives from practicing in one of the three
hospitals, the doctors refused to produce a copy of the committee’s
report.163 One of the defendant obstetricians told the midwives that, if
they were to reapply, the obstetrics department would adopt new poli-
cies “regarding mandatory enemas, perineal shaving, electronic fetal
monitoring, intravenous fluids and ambulation, and would close the
birthing room.”164 The plaintiff midwives also produced a record of a
meeting between three obstetricians who discussed the ways in which
they could prevent the nurse midwives from practicing.165

Additionally, the insurer for the obstetricians dropped medical
malpractice coverage for the physician, Martin, who was willing to
work with the midwives.166 Hibbett, one of the doctors opposed to
allowing the nurse midwives hospital privileges, told an obstetric
nurse, “we’re going to get Dr. Martin’s insurance,” and “we would set
nurse midwifery back twenty years.”167 The underwriting committee
for obstetricians did in fact decide to drop coverage for Martin’s mal-
practice insurance without even reviewing the protocols that would
have been followed when working with the midwives.168

In coming to their decision, the Sixth Circuit applied the Intra-
corporate Conspiracy Doctrine from Section 1 of the Sherman Act.169
The Doctrine states that officers or employees of a corporation are
shielded from alleged conspiracy with agents or employees of the
same corporation.170 However, the court found that the obstetricians
were not agents of the hospitals when they recommended against med-

161. Id. at 609.
162. Id.
163. Id.
164. Id.
165. Id. at 610.
166. Id. at 616.
167. Id. at 610.
168. Id.
169. Id. at 614.
170. Id.
The court explained that doctors who practice in hospitals are more than agents of a hospital for antitrust purposes, “because the relationships between a medical staff and a hospital . . . are different than the relationships between a corporation and its agents.” Consequently, the court reversed summary judgment against the obstetrician defendants and remanded for further proceedings.

Over twenty-five years after this ruling, nurse midwifery is offered as a course of study in the University of Vanderbilt School of Nursing, and students complete their practice at the University Hospital. U.S. News and World Report ranks the program the number one nurse midwifery curriculum in the country. But the incorporation of nurse midwives into maternity wards is the exception, not the rule, in the United States. In 2014, midwives attended only eight percent of all hospital births due to more heavy regulation and influence by the ACOG lobby.

**Prosecutions of Midwives in Cases of Fetal Demise**

Thirty-eight states have laws that criminalize the negligent or intentional murder of a fetus. Twenty-three of those states have fetal homicide laws that apply to the earliest stages of pregnancy, including “fertilization.” The number of midwives prosecuted for fetal demise is not immediately clear. In 2002, the last year in which statistics were available for nationwide prosecutions, about fifty midwives have been sentenced to prison for practicing medicine without a license or for fetal demise. Within the last ten years, high profile prosecutions of

171. *Id.* at 614–15.
172. *Id.* at 612.
173. *Id.* at 617.
175. *Id.*
178. *Id.*
midwives have taken place in Maryland and Indiana. The reasons for this are explored in further detail below.

**Regulation**

“It’s right for people to think, ‘Is this the way we should spend our healthcare dollars?’” How states regulate or do not regulate Certified Professional Midwives and Direct Entry Midwives varies wildly. Twenty-four states do not regulate CPMs and DEMs at all, while twenty-six states regulate CPMs to varying degrees. Of the states that do not regulate home birth midwifery, seven prohibit the practice through statute. Of the states that regulate CPMs, three require malpractice insurance, and five require physician supervision.

**Indiana**

Indiana heavily regulates CPMs and DEMs, requiring both malpractice insurance and physician oversight. Prior to July 1, 2015, midwives who practiced homebirths in Indiana could have been criminally prosecuted. In 2013, the Indiana legislature passed a statute that regulated CPMs and DEMs by requiring them to, among other...

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184. D.C. CODE § 7-751.01(6) (2013) (excluding DEMs from its definition of “other health professional”); 415 ILL. COMP. STAT. 60/3 (2013) (prohibits Direct Entry Midwifery through its practice of medicine act); IOWA CODE §§ 147.2, 148.1 (2013); KY. REV. STAT. ANN. § 311.560 (West 2013); MS. CODE ANN., HEALTH OCC. § 14-301 (West 2013); N.C. GEN. STAT. §§ 90-178.1 to -7 (2013) (prohibiting Direct Entry Midwifery through its Midwifery statute and only allowing CNMs); 49 PA. CONS. STAT. § 16.11 (2013) (prohibiting Direct Entry Midwifery through its practice of medicine act); S.D. CODE ANN. § 36-4-8 (2013) (prohibiting the practice of medicine, or any branches thereof without a license).


186. IND. CODE § 25-23-4-3-1 (2015).

things, maintain “sufficient” liability insurance; to obtain an associate degree in midwifery at a minimum; and to be overseen by practicing obstetricians. Critics of the statute claim that the requirements are too onerous for CPMs and DEMs to meet. For example, the statute requires physicians to review all patient encounters between DEMs and patients, but few physicians are actually willing to oversee these practices. This is because physicians’ malpractice insurance may not permit them to collaborate with CPMs and DEMs. Although the statute protects physicians when CPM and DEM treated women are transferred to the physicians because of distress, the statute does not shield physicians from all liability. This requirement for “sufficient” liability insurance will likely drive CPMs and DEMs out of legal home birth midwifery practice.

Colorado

Like Indiana, Colorado now has an extensive licensing and regulation program for CPMs. However, Colorado’s regulatory scheme appears to reflect a compromise between CPMs and obstetricians. Colorado’s Direct-Entry Midwives Practice Act—a bit of a misnomer because it regulates CPMs who have some organized training—contains several important components also found in Indiana’s regulatory scheme. However, Colorado’s legislation does not require that CPMs obtain physician oversight, and it does not require CPMs to obtain liability insurance until the state is able to find affordable liability insurance for them.

Colorado’s Act does require that CPMs register and obtain state licenses. This requirement allows the state to monitor CPMs, receive complaints lodged against individual CPMs, and revoke licenses granted to midwives who do not meet certain standards. In its lobbying “toolbox,” the ACOG recommends that physicians formally op-

190. Id.
191. Id.
193. Id.
194. Id.
195. Id.
196. Id.
pose statutes similar to Colorado’s that license CPMs.197 But the ACOG also recognizes licensing and regulating CPMs as an ongoing “trend.”198 In response, the ACOG encourages informed consumer consent and greater oversight of CPM practice.199

Colorado’s Act also requires CPMs to obtain informed, written consent from clients, and it lays out requirements for disclosure.200 Required disclosures are to cover: the extent of a CPM’s medical training, and what the CPM can and cannot do with regard to medical interventions; a description of the risks of birth at home and conditions that may arise during delivery; whether or not the CPM has liability insurance for midwifery; a warning that, if an obstetrician becomes necessary for a birth, the doctor will be held only to a standard of gross negligence or willful and wanton misconduct; and the creation of a plan that provides for transporting a woman from a home setting to a hospital if a medical emergency arises.201

The state also requires CPMs to follow regulations set out by the Colorado Department of Regulatory Agencies.202 These regulations consist of standards for antepartum, intrapartum, postpartum, and newborn care; and requirements related to record keeping, emergency plans, vaginal births after cesarean sections (VBAC), and the administration of intravenous fluids.203 The regulations also require a midwife to refer a mother to a “qualified health care provider” if the pregnant woman suffers from gestational diabetes, hyperemesis after the twenty-fourth week of gestation, high blood pressure, preeclampsia, seizures, vaginal bleeding, sexually transmitted infections, fevers, anemia, polyhydranmnios or oligohydramnios, decreased fetal movements, inability to hear fetal heart tones, ruptured membranes with Group B Streptococci infection, premature labor, active herpes infection, intrauterine growth retardation, or a suspected pelvic abnormality.204 This list comes directly from the ACOG’s recommendations for midwives’ referrals to physicians.205 Significantly, these regulations also closely mirror the training that the North American Registry of

198. Id.
199. Id.
201. Id.
202. Id.
203. Id.
204. Id.
205. Legislative Toolkit, supra note 197.
Midwives requires for CPM certification. In other words, Colorado requires and the ACOG recommends that CPMs meet a level of care that CPMs have already set for themselves.

Nevada

Colorado incorporated some of the ACOG’s recommendations into the routine practices of CPMs. But is this compromise in the best interest of women as consumers? Several other states choose to forgo statutes and regulations that govern midwifery in favor of a laissez faire philosophy. Nevada is such a state. Nevada does not regulate CPMs or DEMs, and the number of practicing DEMs in Nevada is unknown. According to “Citizens for Midwifery,” a midwifery advocacy group, CPMs and DEMs in Nevada practice openly, and they “are generally treated respectfully by government and medical agencies and personnel.” All DEMs in Nevada have homebirth practices. On the other hand, Nevada does regulate nurse-midwives who practice in hospitals, and state laws require nurse-midwives to practice in hospitals under the direction of doctors.

Nevada has no statutes that address homebirth or lay midwifery, and no case governs lay midwifery practices. The decision to prosecute midwives who attend home births that end in fetal demise is at the prosecutors’ discretion. In 1999, the Las Vegas District Attorney filed charges of felony child abuse and neglect—a charge that carried a potential punishment of two to twenty years in prison—against a nurse midwife who attended the home birth of an infant who aspirated meconium. The baby did not die, but suffered from hypothermia, respiratory problems and pneumonia. Three months after the District Attorney filed initial charges, the DA dropped the

209. Id.
210. Id.
212. Id.
213. Id.
214. Id.
charge because doctors explained that the midwife’s interventions for the infant were “good enough so long-term health problems were avoided.”

In a letter defending home birth midwifery in Nevada, midwife Corinne Platt wrote to *The Las Vegas Sun* to explain the difference in philosophy between midwives and advocates of medical models of birth:

> [T]he practice of midwifery has nothing to do with the practice of medicine. Pregnancy is not a medical condition, and birth is not a medical event . . . Obstetricians and neonatalogists should be heroes. They have dedicated their lives to learning how to save mothers and babies through heroic measures in those rare times when nature fails.

Midwives are trained to enhance and protect nature; doctors are trained to find and then fix dysfunction and disease. Ideally, midwives and doctors would work together, as they do in all of the countries where birth is the safest . . . Lawyers have done more to make birth unsafe and unsatisfying than any other single issue. Regardless of where or with whom mothers chose to birth their babies, they should get referrals and references, get to know their practitioner, and choose one who will honor the body, mind and spirit.

Platt argues that the midwifery practice should not be held to—or litigated under—the same standards as the practice of medicine because homebirth midwifery is not the practice of medicine. But this is disingenuous. While midwives do not practice medicine in the form of vaginal exams and other “interventions” during childbirth, midwives do practice some form of medicine, even if a rudimentary one. They do so when they give pre-natal exams and tests, and when they take emergency action during or after the birth process by giving injections, engaging in manual interventions, and administering oxygen.

Furthermore, the notion of “not practicing medicine” raises a new question: are pregnant women fully informed consumers of midwifery services and aware of the limitations on those services in a state

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217. *Id.*

218. *State by State, supra* note 207 (stating which states allow non-nurse midwives to administer medicines, conduct exams and administer oxygen).
like Nevada that does not require disclosure? And do women know which questions to ask lay midwives regarding their level of training; their philosophy regarding transporting when women or fetuses are in distress; or their willingness to administer certain drugs? No empirical data exists regarding how well informed women are when they solicit midwives. Homebirth midwifery in Nevada is a self-regulating industry, and it is up to the consumer to beware. Yet it is unclear if consumers are sufficiently informed to ask the appropriate questions with regard to home birth.

**Recommendations**

“We were told that a decision was made that no more midwives will be added to the medical staff because the midwives were getting too busy and that ‘There are people who don’t want this to turn into a midwifery hospital.’”

Midwifery care, when practiced properly, is more cost-effective and safer for low-risk pregnancies than obstetric and hospital care. Additionally, many mothers prefer midwifery care over obstetric based care. Yet in the U.S., state laws and regulatory schemes frequently prevent midwives from practicing, both in and out of hospitals. This is because doctors possess considerable political and market powers, exerting influence over state legislatures and local patient populations. As a result of this competition doctors tend to use their political and market power to reduce the prevalence of midwives, and this dynamic produces poorer outcomes for a large number of mothers and infants.

The challenge then for health care policy makers and health care providers is to transform maternity care from an industry beset by competing economic interests, in which providers are motivated primarily by a desire to maximize their economic interests, to a maternity system in which lowering maternal and fetal mortality rates are the primary goals, and in which greater individual choice and lower overall costs are secondary.

Such radical change is unlikely to be forged in U.S. Courts under due process or right to privacy theories that challenge state regulations. It is also less likely to result from antitrust suits against hospitals and doctors, or filings with the FTC to break up local provider monopolies. The fastest way to affect such a change would be through comprehensive legislation and regulation that would normalize birth without intervention, and would result in induction and C-sections becoming medical last resorts.

States should create the conditions that decrease incentives obstetricians have for over-medicalizing births, and increase incentives for midwives and obstetricians to collaborate. First, states should closely regulate insurance reimbursement rates so that doctors are not reimbursed in a piecemeal or a la carte way. Insurance providers should reimburse doctors for labor rather than discrete services, similar to the way doctors in the U.K. are reimbursed. By paying doctors for labor rather than discrete services, we discourage the over-use of C-sections among other interventions that are highly remunerated. In addition, states should incentivize cooperation between doctors and home birth midwives by requiring insurance companies to reimburse doctors who cooperate with midwives in both hospital and home birth settings.

Next, states should regulate midwives in a way similar to Colorado’s regulatory scheme for home birth midwifery. For example, Colorado requires home birth midwives to have malpractice insurance, but the state also works to find affordable insurance for them. This kind of cooperation between the state and the midwifery profession will help establish midwifery practices in states that currently do not have a market for hospital or home birth practices.

On the other hand, Colorado licenses midwives according to the standards of national midwifery organizations, and those standards may not be sufficient. In order to gain certification as a home birth midwife in Colorado, a midwife must be trained to the satisfaction of the American Midwifery Certification Board. But there is some well-founded concern that the level of training preparing CNMs to assist with homebirths is insufficient. States can look to Europe for guidance on the appropriate level of training a midwife should have for attending homebirths, as well as the standards under which a woman should be referred to a hospital for birth. Additionally, states should regulate when CNMs must refer women to hospitals or obtain a woman’s written consent. This is consistent with European best practices, in accordance with which twins and breech fetuses are delivered in hospitals exclusively.

Additionally, States should require midwives who lack credentials to distribute consent forms that explain that they lack formal training. Colorado’s requirement that midwives present disclosures that inform women of their credentials and make clear what a midwife trained in a particular way can and cannot do medically help to inform women as
consumers. By requiring all birth attendants to inform women of their credentials, states like Nevada do not necessarily need to criminalize DEMs or traditional midwives who do not have credentials. Therefore, the consent form should also outline the midwives’ philosophy on transport if the mother or fetus is distressed, along with other emergency considerations. By requiring these sorts of disclosures, states could provide women with a full range of birthing and midwifery options while also informing women of the risks and benefits associated with home birth.

**Conclusion**

Americans spend $111 billion on maternity care, more than any other country in the world, though we rank sixtieth in the world for successfully preventing maternal mortality deaths. Evidence exists that shows American over-medicalization of birth harms women and babies. Yet it is precisely because maternity care is highly lucrative that makes appropriate changes to the industry slow and difficult. Powerful interests have no incentive to change. Therefore, states should take affirmative steps to incorporate midwifery care into an overall birthing system. States should begin to regulate insurance reimbursement rates so that doctors are not reimbursed in a piecemeal or a la cart way, but for their efforts to prevent unnecessary procedures. States can look to Europe for midwifery care standards and attitudes toward birth. Replacing incentives to over-medicalize birth with incentives to provide holistic care is the start to improving outcomes for everyone.