

SOLVING THE MODERN “MIDWIFE PROBLEM”: THE CASE FOR NON-NURSE MIDWIFERY LEGISLATION IN PENNSYLVANIA*

I. INTRODUCTION

On January 30, 2011, Daniel Kravets was born.¹ On February 2, 2011, he died.² Daniel died from complications of a group B streptococcal (GBS) infection.³ Daniel’s mother, Julia, received prenatal care from Diane Goslin, a non-nurse midwife.⁴ During Julia’s pregnancy, her urine tested positive for GBS.⁵ GBS in the urine is a risk factor for newborn GBS infection.⁶ Julia should have received intravenous (IV) antibiotics during labor to protect Daniel from a GBS infection.⁷ But she did not because Diane Goslin, as a non-nurse midwife in Pennsylvania, could neither legally prescribe, obtain, nor administer IV antibiotics.⁸

Despite a grand jury finding that Diane Goslin’s care “fell well below the accepted maternity standard of care in several regards and resulted in serious risk to the welfare of her patients and their newborn babies,”⁹ no licensing board

* Linda Levinson, M.S. in Nursing, J.D. Candidate, Temple University Beasley School of Law, 2019. The author attended hundreds of deliveries as a certified nurse-midwife in a freestanding birth center and a hospital. Thank you to Professor Frank McClellan for advising me. Thank you to Sarah Beebe for participating in an interview. Thank you to Sonya Bishop, Nick Kato, Andrei Konsen, Brandon Matsnev, Professor Rachel Rebouché, and Kevin Todorow for reviewing drafts. Thank you to the entire *Temple Law Review* staff for their editing, particularly Peter Hyndman, Tim Kelly, and Cameron Redfern.

1. Report No. 1 at 7, *In re Lancaster County Investigating Grand Jury*, No. 966-2012 (Pa. Ct. Com. Pl. Feb. 20, 2013) [hereinafter *Grand Jury*].

2. *Id.* at 9.

3. *Id.* at 10. GBS infection is the leading cause of newborn sepsis in the United States. Jennifer R. Verani et al., *Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CDC, 2010*, DHHS MORBIDITY & MORTALITY WKLY. REP., Nov. 19, 2010, at 1, 1. Maternal colonization with GBS, which occurs in 10 to 30% of pregnancies, is the greatest risk factor for GBS sepsis. *Id.* at 3–4.

4. *Grand Jury*, *supra* note 1, at 7–8. This Comment defines the term non-nurse midwife as any provider who purports to be a midwife who is not a certified nurse-midwife (CNM) or certified midwife (CM). This includes designations such as certified professional midwife (CPM), direct entry midwife, lay midwife, traditional midwife, empirical midwife, and community midwife. See *infra* Part II.A for a discussion of the types of midwives in the United States.

5. *Grand Jury*, *supra* note 1, at 8. Julia was diagnosed with a urinary tract infection (UTI) and treated with antibiotics by a physician. *Id.* Diane Goslin was aware that Julia tested positive for GBS. *Id.* at 9.

6. Verani et al., *supra* note 3, at 7.

7. *Cf. id.* at 7 (recommending intrapartum IV antibiotic treatment for women with GBS bacteriuria).

8. See *Grand Jury*, *supra* note 1, at 10 n.5 (“[Diane Goslin] had no collaborative agreement with a physician who could prescribe antibiotics to treat GBS.”).

9. *Id.* at 45 (footnote omitted).

took action against her.¹⁰ This is because Pennsylvania neither licenses nor regulates non-nurse midwives, which means that they are an essentially unregulated profession.¹¹

This regulatory dearth means that non-nurse midwives in Pennsylvania are not well-integrated members of Pennsylvania's health care system.¹² Thus non-nurse midwives cannot access critical medical interventions: They lack the ability to legitimately order diagnostic bloodwork and ultrasounds.¹³ They lack legal access to antibiotics and medications to treat postpartum hemorrhage.¹⁴ Additionally, consultation and collaboration with and referral to other health care providers is difficult.¹⁵ All of these factors coalesce to make birth with a non-nurse midwife in Pennsylvania less safe than it should be,¹⁶ a situation that the Kravets family personally experienced.

Non-nurse midwives, however, provide a valuable service to Pennsylvania women¹⁷ and families who desire an out-of-hospital birth.¹⁸ Increasing numbers

10. See *id.* at 46 (noting that the investigation into Diane Goslin's conduct "landed . . . in the hands of the Grand Jury, rather than that [sic] of a public health agency").

11. See *id.* at 44–45. See *infra* Part II.C for an explanation of why Pennsylvania neither licenses nor regulates non-nurse midwives.

12. See Saraswathi Vedam et al., *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, PLOS ONE, Feb. 21, 2018, at 1, 8–9 (reporting Pennsylvania's relatively low midwifery integration score); see also Indra Lusero, Note, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN'S RTS. L. REP. 406, 408–413 (2014) (describing administrative barriers to non-nurse midwifery practice).

13. See *Grand Jury*, *supra* note 1, at 4. Some non-nurse midwives in Pennsylvania will provide false information in order to obtain this testing or collaborate with a physician who legitimately orders this testing. *Id.*

14. See *id.* Non-nurse midwives in Pennsylvania utilize various techniques to gain access to these medications and provide them to their clients when necessary. *Id.*

15. See Donna M. Peizer, *A Social and Legal Analysis of the Independent Practice of Midwifery: Vicarious Liability of the Collaborating Physician and Judicial Means of Addressing Denial of Hospital Privileges*, 2 BERKELEY WOMEN'S L.J. 139, 161 n.82 (1986).

16. Cf. Vedam et al., *supra* note 12, at 11–12 ("In our state-by-state comparison . . . the best outcomes for mothers and babies occur in states where all types of midwives are regulated and integrated into the health care system regardless of birth setting."); Am. C. Nurse-Midwives & Am. C. Obstetricians & Gynecologists, *Joint Statement of Practice Relations Between Obstetrician-Gynecologists and Certified Nurse-Midwives/Certified Midwives*, AM. C. OBSTETRICIANS & GYNECOLOGISTS (Apr. 2018), <http://www.acog.org/-/media/Statements-of-Policy/Public/87ACNM-CollegePolicy-Statement—June-2018.pdf> [<http://perma.cc/4GXM-DDEV>] ("[H]ealth care is most effective when it occurs in a system that facilitates communication across care settings and among clinicians.").

17. This Comment refers to people who experience childbirth as women and uses feminine pronouns, but acknowledges that there are men who give birth as well.

18. *Grand Jury*, *supra* note 1, at 44. This Comment uses the term out-of-hospital birth to refer to births that occur in freestanding birth centers and home births. A freestanding birth center is a health care facility that is not located within a hospital where women receive obstetric care before, during, and after birth in a home-like environment. *What Is a Birth Center?*, AM. ASS'N BIRTH CTRS., http://www.birthcenters.org/page/bce_what_is_a_bc [<http://perma.cc/U27B-KS38>] (last visited Nov. 1, 2018).

of women in the United States are choosing to have an out-of-hospital birth.¹⁹ The percentage of out-of-hospital births rose from 0.9% in 2007 to 1.5% in 2015.²⁰ In 2015, 63.1% of out-of-hospital births occurred at home and 30.9% in a freestanding birth center.²¹ Non-nurse midwives attended²² 41.2% of out-of-hospital births in 2015.²³

Pennsylvania has a high home-birth rate,²⁴ and non-nurse midwives attend most Pennsylvania home births.²⁵ In 2015, non-nurse midwives attended at least 1,300 deliveries in Pennsylvania.²⁶ All of the non-nurse midwives who attended these deliveries did so illegally.²⁷ Non-nurse midwives in Pennsylvania practice illegally because the Midwife Regulation Law proscribes midwifery practice without a license, and Pennsylvania currently provides no path to licensure for non-nurse midwives.²⁸

The remainder of this Comment proceeds in three sections. Section II

19. See Joyce A. Martin et al., *Births: Final Data for 2015*, CDC NAT'L VITAL STAT. REP., Jan. 5, 2017, at 1, 9 (gathering data reported on birth certificates). Although the 2003 U.S. Standard Certificate of Live Birth, used by forty-eight states, see *id.* at 2, differentiates between planned and unplanned home births, see DHHS, GUIDE TO COMPLETING THE FACILITY WORKSHEETS FOR THE CERTIFICATE OF LIVE BIRTH AND REPORT OF FETAL DEATH 9 (2016), these data do not. Thus, there are some limitations to inferring trends in planned home-birth rates exclusively using birth certificate data. See Ruth Zielinski et al., *Planned Home Birth: Benefits, Risks, and Opportunities*, 7 INT'L J. WOMEN'S HEALTH 361, 370 (2015).

20. Martin et al., *supra* note 19, at 9.

21. *Id.*

22. This Comment will use the term attended to refer to providing intrapartum care including the delivery of the baby. Many midwives prefer to use the term “catch” to emphasize the birthing woman’s active role and deemphasize what is viewed as the midwife’s passive, noninterventionist role in the process. See Melissa Garvey, *Midwives Don’t Deliver? What’s the Catch?*, MIDWIFE CONNECTION (Feb. 4, 2010, 9:31 AM), <http://acnm-midwives.blogspot.com/2010/02/midwives-dont-deliver-whats-catch.html> [<http://perma.cc/WX2L-R99W>]. The term attended is used here because of its more widespread usage. See *id.*

23. See Martin et al., *supra* note 19, at 55 (61,041 total births occurred not in a hospital; 25,159 were designated as attended by “other midwife”). “Other midwife” is a midwife other than a certified nurse-midwife (CNM) or certified midwife (CM). See NAT'L CTR. FOR HEALTH STATISTICS, *supra* note 19, at 26. See *infra* Part II.A for a discussion of the types of midwives in the United States.

24. See Martin et al., *supra* note 19, at Supplemental Table I-12. At 1.8%, Pennsylvania has the tenth-highest rate of home birth in the United States; 2,542 home births occurred in Pennsylvania in 2015. See *id.*

25. See *Nativity, 2007–2016 Results*, CDC WONDER, <http://wonder.cdc.gov/nativity-current.html> [<http://perma.cc/RDM8-RZDR>] (Click “I Agree” button; then select “Group Results By Birthplace And By Medical Attendant” in the “1. Organize table layout” menu; then select “+ 42 (Pennsylvania)” in the “2. Select maternal residence” menu; then select “Freestanding Birth Center,” “Clinic/Doctor’s Office,” “Residence,” and “Other” under “Birthplace” and “2015” under “year” in the “4. Select birth characteristics” menu; then hit “Send” at the bottom of the page). Certified nurse-midwives (CNMs) attend a large number of home births as well. *Id.* Births in freestanding birth centers in Pennsylvania are dominantly attended by CNMs. See *id.*

26. See *id.* (interpreting “other midwife” as non-nurse midwife, non-nurse midwives attended 368 deliveries in freestanding birth centers and 1,001 home births).

27. See *infra* Part II.C for a discussion of the legal status of non-nurse midwives in Pennsylvania.

28. See 63 PA. STAT. AND CONS. STAT. ANN. §§ 171–76 (West 2018). See *infra* Part II.C.1 for a discussion of the Midwife Regulation Law.

contextualizes midwifery in Pennsylvania and ultimately recommends that the Pennsylvania legislature repeal the outdated Midwife Regulation Law and replace it with new legislation licensing non-nurse midwives. Then Section III explores midwifery and public health and concludes that existing law governing non-nurse midwifery in Pennsylvania does not benefit public health. Section IV of this Comment suggests a statutory framework for Pennsylvania after surveying how other select states have legislated (or not) in the area. Accordingly, it argues that thoughtful and meaningful regulation of non-nurse midwives in Pennsylvania, who are currently practicing without oversight, would benefit non-nurse midwives and improve public health. To achieve this goal, non-nurse midwives in Pennsylvania should (1) be licensed by a newly created Midwifery Regulatory Board, (2) meet the minimum education requirements of the North American Registry of Midwives (NARM), (3) have the ability to practice without a formal collaborative agreement with a physician, and (4) be required to carry malpractice insurance like all other obstetric providers in Pennsylvania. Additionally, an exception to licensure should be made for non-nurse midwives who are members of Plain communities.

II. MIDWIFERY IN PENNSYLVANIA

Well-crafted and responsible legislation requires careful consideration of the problem it seeks to solve. The current midwife problem is a reflection of over one hundred years of professional tensions, a murky statutory and administrative framework, and an ever-changing societal landscape. Section II contextualizes Pennsylvania's current midwife problem by exploring its vibrant history.

This Section proceeds in five parts. Part II.A begins by explaining the different types of midwives in the United States. Part II.B briefly reviews the history of the midwife problem in the United States and Pennsylvania. Part II.C discusses the statutes and case law that affect non-nurse midwives in Pennsylvania. Part II.D summarizes the current status of non-nurse midwifery in Pennsylvania. Part II.E discusses previous attempts to solve the midwife problem and concludes that legislation is the superior approach.

A. *Types of Midwives*

There are two primary types of midwives²⁹ in the United States: certified nurse-midwives (CNMs) and non-nurse midwives.³⁰ Many generic terms are used

29. This Comment uses the generic term midwife to refer to all midwifery practitioners. When used historically, it is essentially referring only to non-nurse midwives because nurse-midwives did not exist in the United States prior to the 1920s. See HELEN VARNEY & JOYCE BEEBE THOMPSON, A HISTORY OF MIDWIFERY IN THE UNITED STATES: THE MIDWIFE SAID FEAR NOT 83 (2016). When used here, it collectively refers to nurse-midwives and non-nurse midwives.

30. There are also certified midwives (CMs). *Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S.*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf> [<http://perma.cc/RDM8-RZDR>] (last visited Nov. 1, 2018) [hereinafter ACNM, *Comparison*]. The CM credential is very similar to the CNM credential, but CMs have a bachelor's degree in a non-nursing field. *Id.* This Comment does not

to refer to non-nurse midwives that provide little information about their particular qualifications.³¹ The term certified professional midwife (CPM) refers to a particular subset of non-nurse midwives.

1. Certified Nurse-Midwives

A CNM is a trained and certified nurse who has also received post-basic training in midwifery.³² A CNM holds a graduate degree in nursing and must attend a midwifery school that is accredited by the U.S. Department of Education.³³ After graduation, a CNM is eligible to sit for the national certification exam administered by the American Midwifery Certification Board (AMCB).³⁴ Successful completion of this exam gives a CNM her³⁵ national certification.³⁶ In order to maintain her national certification, a CNM must participate in the AMCB’s Certificate Maintenance Program in five-year cycles.³⁷ A CNM must also be licensed in the state(s) where she practices.³⁸

A CNM is a primary care provider who may independently evaluate, assess, treat, and refer patients.³⁹ CNMs provide family-centered, individualized, and

discuss CMs separately because they have a similar scope of practice to CNMs, are limited in number, are currently licensed in only a few states, and are not licensed in Pennsylvania. *Id.*; see also *Essential Facts About Midwives*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005948/EssentialFactsAboutMidwives-021116FINAL.pdf> [http://perma.cc/N5B3-4ARY] (last visited Nov. 1, 2018) [hereinafter ACNM, *Essential Facts*].

31. Generic terms used to refer to non-nurse midwives include direct entry midwife, lay midwife, traditional midwife, empirical midwife, and community midwife. VARNEY & THOMPSON, *supra* note 29, at 126.

32. See *Core Competencies for Basic Midwifery Practice*, AM. C. NURSE-MIDWIVES 1 (Dec. 2012), <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000050/Core%20Comptencies%20Dec%202012.pdf> [http://perma.cc/FL2R-LMTJ] [hereinafter ACNM, *Core Competencies*]; *Definition of Midwifery and Scope of Practice of Certified Nurse-Midwives and Certified Midwives*, AM. C. NURSE-MIDWIVES (Dec. 2011) <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000266/Definition%20of%20Midwifery%20and%20Scope%20of%20Practice%20of%20CNMs%20and%20CMs%20Dec%202011.pdf> [http://perma.cc/SJN3-HKPV] [hereinafter ACNM, *Scope of Practice*].

33. ACNM, *Comparison*, *supra* note 30.

34. *The Certification Exam*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/The-Certification-Exam> [http://perma.cc/G5WV-VY7E] (last visited Nov. 1, 2018); see also ACNM, *Core Competencies*, *supra* note 32, at 1.

35. Feminine pronouns are used to refer to midwives throughout this article because more than 99% of midwives are female. See Deanna Pilkenton & Mavis N. Schorn, *Midwifery: A Career for Men in Nursing*, MEN NURSING J., Feb. 2008, at 29, 30 (noting that 0.6% of the ACNM’s members are men).

36. See *Step-by-Step Exam Application Process*, AM. MIDWIFERY CERTIFICATION BOARD, <http://www.amcbmidwife.org/amcb-certification/application-process> [http://perma.cc/F3UK-B8JL] (last visited Nov. 1, 2018).

37. *Purpose/Objectives*, AM. MIDWIFERY CERTIFICATION BOARD, <http://www.amcbmidwife.org/certificate-maintenance-program/purpose-objectives> [http://perma.cc/BWR3-C4KC] (last visited Nov. 1, 2018). The Certificate Maintenance Program allows a CNM to either take and pass the AMCB Certification Examination every five years or complete three Certificate Maintenance Modules and twenty contact hours of approved continuing education units. *Id.*

38. See ACNM, *Comparison*, *supra* note 30.

39. See ACNM, *Core Competencies*, *supra* note 32, at 1; *Position Statement: Midwives Are*

culturally sensitive care for women before, during, and after birth; gynecological care for women from before puberty to after menopause; and newborn care until twenty-eight days of life.⁴⁰ CNMs are noninterventionist and recognize pregnancy, birth, and menopause as normal.⁴¹ Their decisions are science- and evidence-based, and they encourage women and their families to take an active role in health care decisionmaking.⁴² CNMs are licensed and have prescriptive authority in all fifty states.⁴³ CNMs practice in a variety of settings: hospitals, birth centers, homes, and clinics.⁴⁴ There are approximately 11,800 CNMs in the United States.⁴⁵

2. Certified Professional Midwives

A CPM is a midwife who is not required to have nursing training.⁴⁶ A CPM either apprentices with a qualified midwife⁴⁷ or attends a midwifery school.⁴⁸ Apprentice-trained CPMs must establish that they meet certain experience and skills requirements to be eligible to sit for the NARM Written Examination.⁴⁹ Regardless of how a CPM acquires her training, she must sit for and pass the NARM Written Examination to receive her CPM certificate.⁵⁰ In order to maintain her national certification, a CPM must be recertified every three

Primary Care Providers and Leaders of Maternity Care Homes, AM. C. NURSE-MIDWIVES 1 (June 2012), <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000273/Primary%20Care%20Position%20Statement%20June%202012.pdf> [<http://perma.cc/8CPK-8BQ9>].

40. *Position Statement: Collaborative Management in Midwifery Practice for Medical, Gynecologic and Obstetric Conditions*, AM. C. NURSE-MIDWIVES (Sept. 2014) <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000058/Collaborative-Mgmt-in-Midwifery-Practice-Sept-2014.pdf> [<http://perma.cc/X92E-NBV5>]; *Position Statement: Independent Midwifery Practice*, AM. C. NURSE-MIDWIVES (Dec. 2017), <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000073/PS-Independent-Midwifery-Practice-FINAL-Feb-2018.pdf> [<http://perma.cc/ZVB2-ZZ4H>]; ACNM, *Scope of Practice*, *supra* note 32.

41. ACNM, *Core Competencies*, *supra* note 32, at 2.

42. *See Our Philosophy of Care*, AM. C. NURSE-MIDWIVES, <http://www.midwife.org/Our-Philosophy-of-Care> [<http://perma.cc/DSN6-6RDG>] (last visited Nov. 1, 2018).

43. ACNM, *Essential Facts*, *supra* note 30.

44. ACNM, *Comparison*, *supra* note 30.

45. ACNM, *Essential Facts*, *supra* note 30 (noting that the AMCB has issued 11,826 CNM credentials as of August 2017).

46. N. AM. REGISTRY OF MIDWIVES, CERTIFIED PROFESSIONAL MIDWIFE (CPM) CANDIDATE INFORMATION BOOKLET (CIB) 7 (2018) [hereinafter NARM, CPM CIB], <http://narm.org/pdf/files/CIB.pdf> [<http://perma.cc/R7MH-3AZC>] (not including nursing degree as prerequisite for certification).

47. A CPM or CNM with at least three years of experience and/or fifty births. *Id.* at 6.

48. *See id.*

49. *Id.* The applicant must observe at least ten births; attend at least twenty births, twenty-five prenatal visits, twenty newborn exams, and ten postpartum visits as an assistant under supervision; and attend at least twenty births, seventy-five prenatal visits, twenty newborn exams, and forty postpartum exams as the primary midwife under supervision. *Id.* at 8–9.

50. *See Entry Level Applicants*, N. AM. REGISTRY MIDWIVES, <http://narm.org/entry-level-applicants/> [<http://perma.cc/B8A9-WSN8>] (last visited Nov. 1, 2018) [hereinafter NARM, *Entry Level Applicants*].

years.⁵¹ A CPM might also need to be licensed (if available) in the state(s) where she practices.⁵² CPMs, like CNMs, are noninterventionist and recognize pregnancy, birth, and menopause as normal.⁵³ CPMs primarily practice in out-of-hospital settings, attending births in freestanding birth centers or in homes.⁵⁴ They tend to have low-volume practices, delivering three to six babies per month.⁵⁵ There are approximately three thousand CPMs in the United States.⁵⁶

B. *The “Midwife Problem” Then and Now*

The debate over how best to regulate midwifery is not new. At the turn of the twentieth century, obstetricians lobbied legislatures for strict regulation of midwifery practice, leading to the near eradication of midwives and out-of-hospital birth. This time period is discussed in Part II.B.1. A renewed interest in out-of-hospital birth has come with renewed strategies for regulating midwives. This time period is discussed in Part II.B.2.

1. The Original “Midwife Problem”

At the turn of the twentieth century, U.S. maternal and infant mortality rates were markedly higher than current rates.⁵⁷ Childbearing women at this time died most frequently of sepsis (also known as puerperal fever), hemorrhage, and preeclampsia.⁵⁸ Subpar obstetric education and delivery practices were the main causes of these high death rates.⁵⁹ Death rates were particularly high in urban areas, likely due to poor sanitary conditions.⁶⁰

At the time, giving birth with a midwife was safer than the alternative for two reasons. First, it was likely that the midwife had more experience attending

51. NARM, CPM CIB, *supra* note 46, at 28–29.

52. See Lusero, *supra* note 12, at 416–17 (discussing state regulatory barriers that midwives face); Vedam et al., *supra* note 12, at 2 (same); ACNM, *Comparison*, *supra* note 30.

53. See NARM, CPM CIB, *supra* note 46, at 49.

54. See *Current Status*, N. AM. REGISTRY MIDWIVES, <http://narm.org/certification/current-status/> [<http://perma.cc/PW6N-YWQD>] (last visited Nov. 1, 2018) [hereinafter NARM, *Current Status*].

55. NARM, *Entry Level Applicants*, *supra* note 50. Based on this, the average CPM attends thirty-six to seventy-two births per year.

56. See NARM, *Current Status*, *supra* note 54.

57. *Achievements in Public Health, 1900–1999: Healthier Mothers and Babies*, 48 DHHS MORBIDITY & MORTALITY WKLY. REP. 849, 849 (1999) [hereinafter *Achievements in Public Health*] (noting that the infant mortality rate in the United States declined almost 99% between 1900 and 1997 and that the time period from 1900 to 1930 had the highest modern U.S. maternal and infant mortality rates in the twentieth century). It is possible that this time period had the highest maternal mortality rate ever because of obstetric intervention, but reliable data prior to this time period do not exist. See Irvine Loudon, *Maternal Mortality in the Past and Its Relevance to Developing Countries Today*, 72 AM. J. CLINICAL NUTRITION 241S, 241S–43S (2000) [hereinafter Loudon, *Maternal Mortality in the Past*].

58. Loudon, *Maternal Mortality in the Past*, *supra* note 57, at 242S–43S; Irvine Loudon, *On Maternal and Infant Mortality 1900–1960*, 4 SOC. HIST. MED. 29, 61–62 (1991) [hereinafter Loudon, *On Maternal and Infant Mortality*].

59. *Achievements in Public Health*, *supra* note 57, at 853.

60. See Loudon, *On Maternal and Infant Mortality*, *supra* note 58, at 54–55.

births than a trained obstetrician.⁶¹ Second, midwives did not perform risky obstetric interventions—like using forceps, cutting episiotomies, and performing cesarean deliveries—that otherwise contributed to the high rates of maternal and neonatal death.⁶²

Despite the superior training and outcomes of midwives at this time,⁶³ beginning around 1900, obstetricians began a campaign to address the “midwife problem.”⁶⁴ Some believe that the primary motivation for this campaign was economic: eliminating the midwife was necessary in order to establish obstetrics as a profession.⁶⁵ An economic rather than public health impetus is bolstered by the fact that obstetricians remained unregulated despite worse health outcomes.⁶⁶ In addition to a desire to control the market, sexism,⁶⁷ xenophobia,⁶⁸ and racism also likely played a part.⁶⁹ Obstetricians offered three possible

61. See Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 *CARDOZO WOMEN'S L.J.* 61, 66 n.43 (2004) (discussing the 1912 observation of a Johns Hopkins Medical School obstetric professor that “most medical students only had the opportunity to witness the delivery of one woman during their schooling”).

62. See *Achievements in Public Health*, *supra* note 57, at 853; Loudon, *Maternal Mortality in the Past*, *supra* note 57, at 242S–43S.

63. See Dale Elizabeth Walker, *A Matter of the Quality of Birth: Mothers and Midwives Shackled by the Medical Establishment and Pennsylvania Law*, 23 *DUQ. L. REV.* 171, 188 (1984) (“In fact, the very midwives excoriated in the literature, especially those practicing in Europe, were better trained in physiology and the complications of pregnancy as well as in the management of labor than were American physicians.”); see also VARNEY & THOMPSON, *supra* note 29, at 34 (“Dr. J. M. Baldy, a physician in Philadelphia, speaking to the regulation of midwives in 1915, observed ‘. . . our statistics in Philadelphia show that patients are as well off, if not better, in the hands of our midwives than they are in the hands of doctors.’”).

64. See, e.g., A.K. Paine, *The Midwife Problem*, 173 *BOS. MED. & SURGICAL J.* 759, 759–64 (1915).

65. See Kerry E. Reilley, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 *SUFFOLK U. L. REV.* 1117, 1119–24 (1986); Walker, *supra* note 63, at 185–87.

66. See Jason M. Storck, *A State of Uncertainty: Ohio's Deficient Scheme of Midwifery Regulation in Historical and National Context*, 8 *QUINNIAC HEALTH L.J.* 89, 94 (2004) (discussing Dr. Joseph B. DeLee's arguments that midwives were preventing obstetricians from gaining the monetary and status benefits enjoyed by their fellow physicians); Walker, *supra* note 63, at 186–87 (“Although such requirements were a laudable attempt to provide laboring women with skilled attendants, the exemption of physicians and medical students from examination was designed to create a situation whereby midwives would face barriers to practice for the sake of the economic and educational interests of medical professionals who remained free to practice regardless of ability.”); Ira S. Wile, *Immigration and the Midwife Problem*, 167 *BOS. MED. & SURGICAL J.* 113, 113–15 (1912) (“The immigrant midwife coming into this country enters into competition with physicians whose training frequently is not as good as her own. Under the stress of economic necessity their fees become low In addition to their technical care, they give nursing attention and serve in the capacity of housekeeper, so that their services are far more valuable to the household . . . than [those] performed by the physician competing for the same class of patrons.”); see also *supra* notes 59–62.

67. See Walker, *supra* note 63, at 188–89 (noting that Pennsylvania's 1913 midwife law used feminine pronouns to refer to midwives and masculine pronouns to refer to physicians).

68. See VARNEY & THOMPSON, *supra* note 29, at 12 (noting that the passing of restrictive midwifery regulation laws coincided with a large influx of European immigrants to large cities like Philadelphia).

69. See *id.* at 35 (noting that at this time, midwives attended about 50% of births in the United States, but the women they attended were more likely to be immigrants or African Americans).

solutions to the midwife problem: eliminate midwives through legislation explicitly outlawing midwifery, educate midwives, or regulate midwives through licensure.⁷⁰

Ultimately, a combination of all of these approaches led to the virtual elimination of non-nurse midwives in Pennsylvania.⁷¹ Although Pennsylvania did not explicitly outlaw midwifery, increasingly restrictive regulations prevented midwives from becoming licensed, and at some point Pennsylvania stopped licensing midwives altogether.⁷² Contemporaneously, nurse-midwifery started to establish itself as a profession.⁷³ For a time, it appeared that Pennsylvania had solved its midwife problem: obstetricians (and eventually CNMs)⁷⁴ attended births, primarily in hospitals.⁷⁵

2. The Modern “Midwife Problem”

The 1960s heralded the new age of the non-nurse midwife.⁷⁶ Women seeking to regain control over their bodies and birthing experiences sought out alternatives to the typical birthing experience in a hospital attended by an obstetrician, but few existed.⁷⁷ These women turned to non-nurse midwives,

70. *See id.* at 35–36.

71. *Cf.* Peizer, *supra* note 15, at 141 (noting that midwifery in the United States was “almost totally extinguished by the early twentieth century”); Polly F. Radosh, *Midwives in the United States: Past and Present*, 5 *POPULATION RES. & POL’Y REV.* 129, 135–36 (1986) (discussing nationwide decline in numbers of non-nurse midwives). Historical data on the numbers of midwives, especially those who were practicing illegally, are difficult if not impossible to obtain. *See* VARNEY & THOMPSON, *supra* note 29, at 38 (noting that in 1912 only six states knew the number of midwives in the state); *see also* U.S. DEP’T. OF HEALTH, EDUC. & WELFARE, 1 *VITAL STATISTICS OF THE UNITED STATES: 1950*, at 13, 95 (1954) (noting that Pennsylvania did not register all births until 1905 and that attendant data were not tabulated until 1935).

72. *See* Act of June 14, 1911, 1911 Pa. Laws 928 (repealed 1913); Act of June 5, 1913, No. 294, 1913 Pa. Laws 441 (repealed 1929); Midwife Regulation Law of 1929, No. 155, 1929 Pa. Laws 160 (codified as amended at 63 PA. STAT. AND CONS. STAT. ANN. §§ 171–76). As in other parts of the country, Pennsylvania’s laws were passed secondary to a physician campaign to eliminate midwifery competition. *See* Walker, *supra* note 63, at 186–87 (“Although such requirements were a laudable attempt to provide laboring women with skilled attendants, the exemption of physicians and medical students from examination was designed to create a situation whereby midwives would face barriers to practice for the sake of the economic and educational interests of medical professionals who remained free to practice regardless of ability.”). Beginning in 1967, the Board of Medicine required midwives to be registered nurses (RNs) in order to practice in Pennsylvania, but it is unclear if the Board was issuing licenses to non-nurse midwives prior to 1967. *See* Brief of the Pennsylvania Medical Society as Amicus Curiae in Support of the Department of State, State Board of Medicine at 20, *Goslin v. State Bd. of Med.*, 949 A.2d 372 (Pa. Commw. Ct. 2008) (No. 1830 CD 2007).

73. *See* VARNEY & THOMPSON, *supra* note 29, at 83–99 (describing the establishment of the nurse-midwifery profession in the United States).

74. CNMs were first licensed in Pennsylvania in 1985. *See* Medical Practice Act of 1985, No. 112, § 35, 1985 Pa. Laws 457, 474 (current version at 63 PA. STAT. AND CONS. STAT. ANN. § 422.35) (establishing licensure requirements for nurse-midwives).

75. *Cf.* U.S. DEP’T. OF HEALTH, EDUC. & WELFARE, *supra* note 71, at 95 (discussing nationwide trends in birth attendant and location).

76. *See* VARNEY & THOMPSON, *supra* note 29, at 126.

77. *See id.*

whose training varied wildly.⁷⁸ The legal status of non-nurse midwives also varied wildly.⁷⁹ Some states interpreted their medical practice acts as prohibiting non-nurse midwives from attending deliveries.⁸⁰ Others relied on relics from the era of the original midwife problem to recognize non-nurse midwives.⁸¹ Eventually, established professions realized that there may be a modern midwife problem.⁸² And again, legislation became the key tool to solving the problem. Some states passed laws explicitly outlawing non-nurse midwives; others passed laws providing non-nurse midwives with a path to licensure.⁸³ Over the past several decades, state legislation has trended in favor of licensing non-nurse midwives.⁸⁴

Consumer demand drove and continues to drive this trend. Women who choose home birth cite a variety of reasons: safety, lower intervention rates, previous negative hospital experiences, greater feelings of control, and a more comfortable environment.⁸⁵ Others view choosing out-of-hospital birth as a form of feminist political action.⁸⁶ The typical woman who has a planned out-of-hospital birth is married, white,⁸⁷ and highly educated.⁸⁸ Additionally, members of Plain communities, such as the Amish, Mennonites, and Brethren,⁸⁹ also

78. See *id.* at 127 (“Their preparation for attending births ranged from couples actively participating in their own childbearing experiences and then offering to help other couples give birth at home, to self-study by reading current editions of obstetrical . . . and midwifery books . . . , attending conferences to learn about pregnancy and birth; and devouring lay books and articles . . . ; and manuals written by lay midwives.” (footnotes omitted)).

79. See *id.* at 337.

80. See *id.*

81. See *id.* at 33, 57, 337.

82. See *id.* at 127–28.

83. See *id.* at 337–40 (comparing state recognition of non-nurse midwives before and after Midwives Alliance of North America (MANA) professionalized non-nurse midwives in 1982).

84. See *id.* at 341–42 (discussing the Big Push for Midwives Campaign).

85. Debora Boucher et al., *Staying Home To Give Birth: Why Women in the United States Choose Home Birth*, 54 J. MIDWIFERY & WOMEN’S HEALTH 119, 121–23 (2009).

86. See Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 553 (1993) (“A high-income white woman who rejects the medical model of childbirth is resisting a vision of herself as an object to be ‘managed,’ as passive, incompetent, selfless, and emotional.”).

87. Discussing the influence of race in the natural childbirth community is beyond the scope of this Comment. For a thoughtful discussion of these issues, see generally Ehrenreich, *supra* note 86, and Danielle Thompson, *Midwives and Pregnant Women of Color: Why We Need To Understand Intersectional Changes in Midwifery To Reclaim Home Birth*, 6 COLUM. J. RACE & L. 27 (2016).

88. Mickey Sperlich et al., *Where Do You Feel Safest? Demographic Factors and Place of Birth*, 62 J. MIDWIFERY & WOMEN’S HEALTH 88, 88 (2017). Only 2% of women who have planned home births are African American. *Id.* at 91. Only 6% of women who give birth in a freestanding birth center are African American. *Id.*

89. Plain is a generic term used to describe a wide variety of Anabaptists. Emily Wiley & Michael Sedon, *Plain People of Pennsylvania*, PA. ST. U. (Nov. 13, 2006), <http://news.psu.edu/story/141058/2006/11/13/research/plain-people-pennsylvania> [http://perma.cc/9H7N-FLDQ]. There is wide variation in beliefs and preferences across these communities. See Donald B. Kraybill, *Negotiating with Caesar*, in *THE AMISH AND THE STATE* 3, 6–7 (Donald B. Kraybill ed., 2d ed. 2003).

frequently plan out-of-hospital deliveries.⁹⁰

The nationwide resurgence of home birth and births attended by non-nurse midwives is also occurring in Pennsylvania.⁹¹ Pennsylvania’s large Plain population of more than 230,000 people is likely contributing to the resurgence.⁹² But Plain women are not the only Pennsylvania women seeking out-of-hospital births. Despite this large consumer demand, and the national trend towards licensure of non-nurse midwives, Pennsylvania’s failure to solve its modern midwife problem persists.

C. Pennsylvania Law Affecting Midwifery

This Part discusses the existing legal structure that influences the statutory recommendations made herein. The Midwife Regulation Law, as interpreted in *Goslin v. State Board of Medicine*,⁹³ governs non-nurse midwifery practice.⁹⁴ The Medical Practice Act governs CNM practice.⁹⁵ The Medical Care Availability and Reduction of Error (MCARE) Act imposes a statutory requirement that obstetricians and CNMs carry malpractice insurance.⁹⁶

1. The Midwife Regulation Law and Non-Nurse Midwives

The Midwife Regulation Law, passed in 1929,⁹⁷ controls the practice of non-nurse midwives in Pennsylvania.⁹⁸ The Midwife Regulation Law requires that those practicing midwifery in Pennsylvania receive a certificate from the State Board of Medical Education and Licensure.⁹⁹ It defines a midwife as “[a]ny person . . . other than a regularly licensed physician or osteopath, who shall attend a woman in childbirth for hire.”¹⁰⁰ The Midwife Regulation Law

90. See Gertrude Enders Huntington, *Health Care, in THE AMISH AND THE STATE*, *supra* note 89, at 171, 172.

91. See *supra* notes 17–27 and accompanying text.

92. Wiley & Sedon, *supra* note 89. There are about 237,000 Anabaptists in Pennsylvania. *Id.* This is about 27% of the United States’ Anabaptist population. *Id.*

93. 949 A.2d 372 (Pa. Commw. Ct. 2008).

94. See 63 PA. STAT. AND CONS. STAT. ANN. §§ 171–76 (West 2018).

95. *Id.* § 422.35.

96. Tit. 40, § 1303.711(a); see also 49 PA. CODE § 16.32(a) (2018) (“[A] nurse-midwife shall maintain the required amount of professional liability insurance, or have an approved self-insurance plan, and pay the required Medical Care Availability and Reduction of Error (MCARE) Fund assessment as a condition of practice under sections 711 and 712 of the MCARE Act.”).

97. Midwife Regulation Law of 1929, No. 155, 1929 Pa. Laws 160 (codified as amended at 63 PA. STAT. AND CONS. STAT. ANN. §§ 171–76).

98. See 63 PA. STAT. AND CONS. STAT. ANN. §§ 171–76; see also *infra* Part II.C.3.

99. Tit. 63, § 171 (“Upon and after the passage of this act, it shall be unlawful for any person or persons, *except a duly licensed physician or osteopath*, to practice midwifery in this Commonwealth, before receiving a certificate from the State Board of Medical Education and Licensure of the Commonwealth of Pennsylvania authorizing such person or persons so to do, and having said certificate registered in the office of the State Board of Medical Education and Licensure at Harrisburg, Pennsylvania.” (emphasis added)).

100. *Id.* § 176.

empowered the then-extant State Board of Medical Education and Licensure¹⁰¹ (now the State Board of Medicine)¹⁰² to promulgate rules and regulations regarding the examination, licensure, and standard of care for midwives.¹⁰³ It also gives the Board the authority to issue and revoke midwifery certificates.¹⁰⁴ It empowers the Secretary of Health to appoint a physician review board to supervise midwives and enforce the statute.¹⁰⁵ It provides penalties for unlicensed midwives practicing midwifery or advertising themselves as midwives: a fine of \$10 to \$100.¹⁰⁶ Some view the Midwife Regulation Law as endorsing a monopoly over childbirth by physicians in Pennsylvania.¹⁰⁷

2. The Medical Practice Act of 1985 and CNMs

The Medical Practice Act of 1985 imposes strict requirements on CNMs¹⁰⁸ to legally practice in Pennsylvania. To qualify for a license, the applicant must meet three criteria: she must be a registered nurse (RN) licensed in Pennsylvania,¹⁰⁹ a graduate of an approved midwifery program,¹¹⁰ and certified

101. *See, e.g., id.* § 171 (requiring certification from “the State Board of Medical Education and Licensure”).

102. *See id.* § 422.3(a) (establishing the State Board of Medicine).

103. *See id.* § 172 (“The State Board of Medical Education and Licensure shall formulate and issue such rules and regulations, from time to time, as may be necessary for the examination, licensing, and proper conduct of the practice of midwifery by midwives. The board, upon recommendation of the Secretary of Health, shall issue certificates to midwives having fulfilled the requirements laid down by the board, which certificates, and any certificates heretofore issued to any midwife under the provisions of any law of this Commonwealth, shall be revocable by the State Board of Medical Education and Licensure, on proof of violation of any of its rules and regulations, or the rules and regulations of the State Department of Health, or of any of the provisions of this act. The said board may refuse to grant a certificate to any person, and may revoke the license of any person, addicted to the use of alcohol or narcotic drugs, or who may have been guilty of a crime involving moral turpitude.”).

104. *See id.*

105. *See id.* § 174 (“The Secretary of Health of the Commonwealth of Pennsylvania shall appoint not more than five physicians, who shall serve as inspectors of midwives and who shall maintain close supervision over, and control and instruct such midwives, in accordance with the directions and suggestions of the Secretary of Health. The provisions of this act shall be enforced by the Secretary of Health.”). The supervisory panel is to be composed of only physicians. *See id.*

106. *See id.* § 175 (“Any person practicing midwifery as a profession, or advertising herself as a midwife, without first obtaining the certificate aforesaid, or lawfully holding a license under the laws of the Commonwealth, shall, upon conviction thereof in a summary proceeding before a [magisterial district judge], alderman or magistrate of the county wherein such violation or offense is committed, be sentenced to pay a fine of not less than ten dollars (\$10.00) and costs, nor more than one hundred dollars (\$100.00) and costs, such fine to be paid to the county in which the violation or offense is committed. In default of payment of such fine and costs, the offender shall be sentenced to be confined in the proper county jail for a period of not exceeding sixty days.”).

107. *See Walker, supra* note 63, at 189–90.

108. *See tit. 63, § 422.2.* The Act’s definition of “[b]oard regulated practitioner” includes “midwife.” *See id.*

109. *Id.* § 422.35(b).

110. *See id.* An approved midwifery program is “[a]n academic and clinical program of study in midwifery which has been approved by the Board [of Medicine] or by an accrediting body recognized by the Board. The Board recognizes the ACNM and ACME . . . as an accrediting body of programs of

by the American Midwifery Certification Board (AMCB).¹¹¹ In order to practice midwifery in Pennsylvania, a nurse-midwife must have a written collaborative agreement with an obstetrician or gynecologist with hospital privileges.¹¹² A collaborative agreement formally delineates the CNM-physician relationship and imposes limitations on the CNM’s practice.¹¹³ The regulations promulgated by the State Board of Medicine limit the nurse-midwife’s practice to what is contained in the midwife practice guidelines and collaborative agreement.¹¹⁴ The midwife practice guidelines lay out procedures for routine midwifery care and the mechanisms for consultation, co-management, referral, and transfer of care between the midwife and the physician.¹¹⁵

The current composition of the State Board of Medicine may assist in the perpetuation of restrictive midwifery laws.¹¹⁶ The Board is empowered to promulgate laws governing CNMs.¹¹⁷ But the Board is dominated by physicians¹¹⁸—a group that previously attempted to eliminate the midwifery profession.¹¹⁹ And the Medical Practice Act essentially precludes other health care professionals who are governed by the Board from sitting on it.¹²⁰

study in midwifery.” See 49 PA. CODE § 18.1 (2018).

111. See 49 PA. CODE § 18.2(4)(i). Midwives certified by ACNM prior to 1971 are exempt from this requirement. See *id.* § 18.2(4)(ii). The Board of Nursing, an administrative agency independent of the Board of Medicine, issues RN licenses. See 63 PA. STAT. AND CONS. STAT. ANN. § 218(a).

112. See tit. 63, § 422.35(d) (“The physician with whom a nurse-midwife has a collaborative agreement shall have hospital clinical privileges in the specialty area of the care for which the physician is providing collaborative services.”).

113. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, TASK FORCE ON COLLABORATIVE PRACTICE, COLLABORATION IN PRACTICE: IMPLEMENTING TEAM-BASED CARE 19–20 (2017) [hereinafter ACOG, COLLABORATIVE PRACTICE]. See *infra* Part IV.B.3 for a discussion of collaborative agreements.

114. See 49 PA. CODE § 18.5(b).

115. See *id.* § 18.4. The collaborative agreement must contain “a predetermined plan for emergency services, and immediate availability of a physician to the nurse-midwife by direct communication or . . . telecommunication.” *Id.* § 18.5(g)(1).

116. See Walker, *supra* note 63, at 189–90.

117. 63 PA. STAT. AND CONS. STAT. ANN. § 422.8.

118. The Board comprises the commissioner, the Secretary of Health, two representatives of the public at large, and seven professional members. *Id.* § 422.3(a). The statute requires that six of the seven professional members are medical doctors. *Id.*

119. See *supra* Part II.B.1 for a discussion of the decline of midwifery at the turn of the twentieth century.

120. The remaining professions regulated under this Act have a single professional member to represent all of their interests. Tit. 63, § 422.3(a). The current nonphysician professional member is John M. Mitchell, a licensed perfusionist. See *Board Member List*, PA. DEP’T ST., <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/Board-Member-List.aspx> [<http://perma.cc/S8PL-FGKR>] (last visited Nov. 1, 2018). Although the Board licenses thirteen different kinds of non-physician professionals, see 49 PA. CODE § 16.11(b), only five are eligible for appointment to the Board: CNMs, physician assistants, respiratory therapists, licensed athletic trainers, and perfusionists, 63 PA. STAT. AND CONS. STAT. ANN. § 422.3(a). Additionally, certified registered nurse practitioners, licensed by the Board of Nursing, are eligible. *Id.*; see also 49 PA. CODE § 21.261(a)–(b).

3. The Midwife Regulation Law Continues To Govern Non-Nurse Midwives

For years following the passage of the Medical Practice Act, the legal status of non-nurse midwives in Pennsylvania was unclear, but they continued to practice without interference from the Commonwealth.¹²¹ This changed in 1989, when the Bureau of Professional and Occupational Affairs filed suit against Lucille Sykes, a non-nurse midwife who primarily provided services to the Amish community.¹²² The Bureau alleged that she was practicing medicine without a license in violation of the Medical Practice Act of 1985 and sought to enjoin her midwifery practice.¹²³ Sykes argued that as a non-nurse midwife, the Act did not apply to her.¹²⁴ The court agreed.¹²⁵ Sykes also argued that “the practice of lay midwifery is not subject to any licensure requirement and is not otherwise regulated, as such, under Pennsylvania law.”¹²⁶ The court declined to decide that issue¹²⁷ but noted in dicta that although the Midwife Regulation Law prohibits unlicensed non-nurse midwifery practice,¹²⁸ “it is questionable whether an effective enforcement provision for its licensure requirement currently exists.”¹²⁹ In other words, the court was uncertain whether the Midwife Regulation Law had any practical effect. Following *Commonwealth v. Sykes*,¹³⁰ the understanding in the non-nurse midwifery community was that “[u]nless reversed in an appellate court, all ‘midwives in Pennsylvania can now rest comfortably . . . that the threat of criminal and/or civil prosecution has been removed.’”¹³¹

Ultimately, this prophecy was wrong. The Bureau of Professional and Occupational Affairs continued to sporadically interfere with non-nurse midwives’ practices.¹³² *Sykes* protected these non-nurse midwives¹³³: it stated that non-nurse midwives were not regulated under the Medical Practice Act, and

121. See Steven Ochs, *Amish, Mennonites Rally for Midwife Bill*, MORNING CALL (Allentown, Pa.) (Mar. 13, 1990), http://articles.mcall.com/1990-03-13/news/2726196_1_amish-women-midwife-kitty-ernst [<http://perma.cc/42A8-DJBZ>].

122. See Huntington, *supra* note 90, at 176–77.

123. See *Commonwealth v. Sykes*, No. 11 E.Q. 1989, slip op. at 1 (Pa. Ct. Com. Pl. Dec. 21, 1990); see also Huntington, *supra* note 90, at 177.

124. *Sykes*, slip op. at 2.

125. *Id.* at 18.

126. *Id.* at 2.

127. *Id.*

128. *Id.* at 11.

129. *Id.* at 8–9.

130. No. 11 E.Q. 1989 (Pa. Ct. Com. Pl. Dec. 21, 1990).

131. Huntington, *supra* note 90, at 178 (quoting Letter from P. Raymond Bartholomew, Attorney, to Salena Walter, President, Pa. Midwives Ass’n, (Dec. 31, 1990)).

132. See, e.g., Susan E. Lindt, *Strasburg Midwife Charged*, LANCASTERONLINE (Jan. 24, 2007), http://lancasteronline.com/news/strasburg-midwife-charged/article_feddc8d1-00c2-5290-8da5-da67fec90112.html [<http://perma.cc/ZS67-VQ2B>] (noting that Diane Goslin was investigated three times before being charged); *Pennsylvania News*, CPM NEWS (N. Am. Registry of Midwives, Lilburn, Ga.), Winter 2005, at 8 (describing action taken against Karen Carr, CPM).

133. See, e.g., *Pennsylvania News*, *supra* note 132, at 8.

the status and enforceability of the Midwife Regulation Law was murky.¹³⁴ But this protection was short-lived. In 2008 an appellate court interpreted the Midwife Regulation Law and the Medical Practice Act and concluded that non-nurse midwives must be licensed to lawfully practice in Pennsylvania.¹³⁵

In *Goslin*, the Commonwealth Court of Pennsylvania reviewed an order from the State Board of Medicine, which ordered Diane Goslin¹³⁶ “to cease and desist from the practices of medicine and midwifery” and imposed civil penalties totaling \$11,000.¹³⁷ The Board concluded that “Goslin violated sections 10 and 39(b) of the [Medical Practice] Act by engaging in the practice of medicine,” as well as section 1 of the Midwife Regulation Law for practicing midwifery without a license.¹³⁸ The Board ruled that Goslin violated the Medical Practice Act by providing “antepartum, intrapartum, postpartum and/or nonsurgically related gynecological care.”¹³⁹ Additionally, the Board determined that Goslin violated the Midwife Regulation Law “by engaging in the practice of midwifery without a license and by holding herself out to the public as a midwife.”¹⁴⁰

The Commonwealth Court vacated the Board of Medicine’s order.¹⁴¹ To do so, the court used canons of construction to interpret the Medical Practice Act and concluded that Goslin did not violate the Act because it does not apply to non-nurse midwives.¹⁴² Its reasoning was as follows: First, providing “antepartum, intrapartum, postpartum and nonsurgically related gynecological care”—the basis for the Board of Medicine’s order—is the definition of “midwifery practice” under the Board’s regulations.¹⁴³ Section 35 of the Medical Practice Act, however, grants licensed CNMs the authority to practice midwifery.¹⁴⁴ Therefore, practicing midwifery is not equivalent to “practicing medicine and surgery” for purposes of determining a violation of sections 10 and 39(b) of the Medical Practice Act.¹⁴⁵ Otherwise, every licensed CNM in Pennsylvania would be guilty of “practicing medicine” without a license.¹⁴⁶ Thus, the court concluded that “the practice of medicine and surgery is distinct from,

134. *Sykes*, slip op. at 8–9, 18.

135. *See Goslin v. State Bd. of Med.*, 949 A.2d 372, 377 & n.12 (Pa. Commw. Ct. 2008).

136. Goslin is Diane Goslin, the CPM who attended the birth of Daniel Kravets three days before his death. *See* Matt Miller, *Grand Jury Calls for Tighter State Regulation of Midwives To Protect Home-Birth Mothers and Babies*, PENNLIVE (October 17, 2013), http://www.pennlive.com/midstate/index.ssf/2013/10/grand_jury_calls_for_tighter_s.html [<http://perma.cc/DY4V-2ZLS>].

137. *Goslin*, 949 A.2d at 373. The Board of Medicine imposed a \$10,000 penalty for “the unlicensed practice of medicine” and a \$1,000 penalty for “the unlicensed practice of midwifery.” *Id.*

138. *Id.* at 374.

139. *Id.* at 375 (citation omitted).

140. *Id.* at 374.

141. *Id.* at 377.

142. *See id.* at 375.

143. *See id.*; *see also* 49 PA. CODE § 18.1 (2018). The regulation defines “midwifery practice” as the “[m]anagement of the care of essentially normal women and their normal neonates. This includes antepartum, intrapartum, postpartum and nonsurgically related gynecological care.” *Id.*

144. *Goslin*, 949 A.2d at 375.

145. *See id.*

146. *See id.* at 375 n.7.

and beyond the scope of, midwifery.”¹⁴⁷ Because the practice of midwifery did not constitute the practice of medicine under the Act, the court held that Goslin did not violate the Medical Practice Act.¹⁴⁸

Once the court decided that Goslin did not violate the Medical Practice Act, it considered whether the Medical Practice Act and the Midwife Regulation Law are different statutes.¹⁴⁹ The court concluded that the Medical Practice Act and the Midwife Regulation Law are two separate statutes with separate purposes relating to two different classes of midwives—CNMs and non-nurse midwives, respectively.¹⁵⁰ Thus, the Midwife Regulation Law continues to govern non-nurse midwives in Pennsylvania.¹⁵¹

D. Current Status of Non-Nurse Midwifery in Pennsylvania

Although the Commonwealth Court provided some clarification in *Goslin*, confusion surrounding the legal status of home birth and non-nurse midwives in Pennsylvania abounds. Part II.D.1 first summarizes the current legal status of non-nurse midwifery practice in Pennsylvania. Then it introduces and dispels common misconceptions about the legal status of non-nurse midwifery practice in Pennsylvania. Part II.D.2 explains that the practical effect of the current legal status on non-nurse midwives is that they practice in a state of uncertainty. Then it concludes that maintaining the legal status quo does not benefit Pennsylvanians.

1. Legal Status

Goslin established that non-nurse midwives are not bound by the Medical Practice Act, including the portion that licenses and regulates CNMs.¹⁵² Therefore, they are not required to meet the educational or collaborative agreement requirements imposed on CNMs.¹⁵³ The Midwife Regulation Law prohibits the practice of midwifery without a certificate from the State Board of Medical Education and Licensure (now the State Board of Medicine).¹⁵⁴ The State Board of Medicine currently does not provide a path to licensure for non-nurse midwives.¹⁵⁵ Therefore, there are no regulations in place dictating their practice—essentially leaving them unregulated.¹⁵⁶

147. *Id.*

148. *See id.* at 375.

149. *See id.* at 376–77. The court had to decide this issue because “Goslin next argue[d] that the Board deprived her of due process by failing to provide notice that she was charged with violating section 1 of the [Midwife Regulation Law].” *Id.* at 375.

150. *Id.* at 377 & n.11.

151. *See id.* at 377. The *Goslin* court held that the State Board of Medicine deprived Goslin of due process for failing to provide notice of her violation of the Midwife Practice Act. *Id.*

152. *See supra* notes 136–51 and accompanying text.

153. *See* 63 PA. STAT. AND CONS. STAT. ANN. § 422.35 (West 2018); *see also supra* notes 136–51 and accompanying text.

154. Tit. 63, § 171.

155. *See* 49 PA. CODE § 16.11(b) (2018).

156. *See Board Laws & Regulations*, PA. DEP’T ST., <http://www.dos.pa.gov/Professional>

Although *Goslin* clarified the legal status of non-nurse midwives in Pennsylvania, confusion abounds in the Pennsylvania childbirth community surrounding the legality of home birth and non-nurse midwifery practice. Some believe that it is “alegal”—neither legal nor illegal¹⁵⁷—to have a home birth in Pennsylvania. For example, Vanessa Manz, writing in *Midwifery Today*, stated:

While homebirth is not technically illegal in the state of Pennsylvania, meaning there are currently no laws regulating birth in the home, it is “alegal”—tolerated in practice, but midwives (traditional as well as certified professional midwives) can be ordered to cease and desist for practicing without a license. This leaves it up to the discretion of the local law enforcement to pursue cases against midwives who attend homebirths that result in transfers to hospitals or result in poor maternal or fetal outcomes.¹⁵⁸

Others believe that it is legal to practice as a non-nurse midwife in Pennsylvania without a license. For example, Valerie Borek, a Pennsylvania attorney, wrote: “Pennsylvania does not license lay midwifery. It is also not prohibited. Don’t be fooled into thinking it’s illegal to attend births as a direct entry midwife in Pennsylvania simply because there is no license available. State courts have confirmed it is neither illegal, nor is it regulated.”¹⁵⁹

To clarify, home birth is legal in Pennsylvania.¹⁶⁰ There are CNMs and physicians in Pennsylvania who legally attend home births.¹⁶¹ *Goslin* confirmed that it remains illegal to practice as an *unlicensed* non-nurse midwife in Pennsylvania.¹⁶² The Midwife Regulation Law does not limit State Board of Medicine intervention to cases with poor maternal or fetal outcomes.¹⁶³ The State Board of Medicine is always empowered to pursue action against an unlicensed non-nurse midwife.¹⁶⁴

2. Practical Effect of Legal Status

As discussed above, there is currently confusion regarding the legality of a non-nurse midwife’s practice in Pennsylvania. This confusion helps neither

Licensing/BoardsCommissions/Medicine/Pages/Board-Laws-and-Regulations.aspx [http://perma.cc/G88N-RDWZ] (last visited Nov. 1, 2018) (lacking mention of non-nurse midwives).

157. See *Alegal*, BLACK’S LAW DICTIONARY (10th ed. 2014).

158. Vanessa Manz, *Answering the Question of Homebirth*, MIDWIFERY TODAY, Spring 2010, at 44, 44.

159. Valerie Borek, *The Empowered Parent: Home Birth Legalities*, CHADDS FORD LIVE (Jan. 7, 2015), <http://chaddsfordlive.com/2015/01/07/the-empowered-parent-home-birth-legalities/> [http://perma.cc/XVA8-3SM4].

160. A thorough review of Pennsylvania’s statutes found no law expressly prohibiting home birth.

161. See, e.g., *Maternity Services*, BIRTH CARE & FAM. HEALTH SERVICES, <http://www.birthcaremidwives.com/maternity.htm> [http://perma.cc/Z8V5-KRAG] (last visited Nov. 1, 2018).

162. See *Goslin v. State Bd. of Med.*, 949 A.2d 372, 377 & n.12 (Pa. Commw. Ct. 2008); see also 63 PA. STAT. AND CONS. STAT. ANN. § 171 (West 2018) (making the practice of midwifery without a license illegal).

163. Tit. 63, § 171.

164. See *supra* notes 101–05 and accompanying text.

advocates nor opponents of non-nurse midwifery practice. Non-nurse midwives in Pennsylvania and their clients live in a state of uncertainty, never knowing when the state may decide to enforce the Midwife Regulation Law.¹⁶⁵ For opponents, allowing non-nurse midwives to practice by failing to enforce the prohibition “undermines respect for state authority.”¹⁶⁶ The detriments of the failure to address this problem are compounded by Pennsylvania’s relatively high home-birth rate, especially in its Plain communities.¹⁶⁷

Pennsylvania’s lack of enforcement of the Midwife Regulation Law is problematic for both non-nurse midwives and their clients.¹⁶⁸ If a client is injured by the actions of a non-nurse midwife, she cannot pursue disciplinary action through the state licensing board.¹⁶⁹ Her only recourse is judicial—she can either file a tort claim or attempt to convince a prosecutor to file criminal charges.¹⁷⁰ But most non-nurse midwives carry little or no malpractice insurance and have low incomes, offering little chance of recovery in a tort action against the non-nurse midwife.¹⁷¹ It is also difficult for even a motivated prosecutor to criminally indict a non-nurse midwife.¹⁷²

Non-nurse midwives in Pennsylvania currently practice in limbo. Enforcement of the Midwife Regulation Law is almost nonexistent.¹⁷³ Without any enforcement, non-nurse midwives enjoy a complete lack of oversight from the Commonwealth, but this freedom is illusory.¹⁷⁴ Non-nurse midwives in Pennsylvania are vulnerable to losing their careers, financial stability, and freedom.¹⁷⁵ Simply because Pennsylvania is currently failing to enforce the Midwife Regulation Law does not mean that it will continue to do so. The Midwife Regulation Law provides for low civil penalties, but it is unclear what

165. See *supra* Part II.D.1 for a discussion of the current legal status of non-nurse midwives in Pennsylvania.

166. See Storck, *supra* note 66, at 99 (discussing Ohio’s lack of clarity on the practice of non-nurse midwives).

167. *Cf. id.* (“Given the state’s interest in healthy child birthing and the desire of many citizens to take advantage of midwifery services, Ohio’s legislative silence on this topic is deafening, particularly in light of the large number of deliveries by [non-nurse midwives] within Ohio’s Amish and Anabaptist communities.”).

168. See Kathleen M. Whitby, *Choice in Childbirth: Parents, Lay Midwives, and Statutory Regulation*, 30 ST. LOUIS U. L.J. 985, 1001–02 (1986) (discussing the substantial effects of illegality of non-nurse midwifery practice on non-nurse midwives and their clients).

169. *Cf.* Deborah M. Fisch, *Baby Steps: The Changing Relationship Between Michigan Obstetricians and Certified Professional Midwives*, 14 MARQ. ELDER’S ADVISER 87, 98 (2012) (discussing Michigan).

170. *Cf. id.* (discussing Michigan).

171. *Id.* See also *infra* Part IV.B.4 for a discussion of non-nurse midwives and malpractice insurance.

172. See, e.g., *Grand Jury*, *supra* note 1, at 45–46 (failing to indict Diane Goslin for her involvement in the death of Daniel Kravets because she did not have the requisite “criminal state of mind”).

173. Searches on Westlaw and LexisNexis revealed a single case reference to the Midwife Regulation Law: *Goslin v. State Board of Medicine*, discussed *supra* notes 136–51.

174. Fisch, *supra* note 169, at 97.

175. *Cf. id.* at 99 (discussing this issue as it exists in Michigan and “most states”).

constitutes a single act, so the penalties may compound.¹⁷⁶ A non-nurse midwife could face charges under the Midwife Regulation Law even if nothing bad happens to women and babies under her care. Lacking the option of initiating disciplinary proceedings, the Commonwealth may opt to bring criminal charges in the event of a bad outcome.¹⁷⁷

Non-nurse midwives tend to come to the attention of authorities when bad outcomes occur or they transfer patients to the hospital; thus, they are incentivized to cover up bad outcomes and avoid transferring patients and newborns to the hospital.¹⁷⁸ Non-nurse midwives who do transfer patients or newborns to the hospital may be reluctant to admit that they attended the woman in labor. This can inhibit the communication of vital information about the health status of the laboring mother and baby, which may lead to unnecessary delay in providing a greater level of care to the mother or child.¹⁷⁹ Merely ignoring the midwife problem is an inadequate response.

E. Legalizing Non-Nurse Midwifery Is the Best Way To Solve the “Midwife Problem”

Although Pennsylvania is currently ignoring the midwife problem, that has not always been the case. Pennsylvanians have made several unsuccessful attempts to solve the midwife problem through criminalization, regulation, litigation, and legalization. This Part highlights some of these attempts, explains why they were unsuccessful, and concludes that legislation explicitly legalizing non-nurse midwifery practice is the best path moving forward.

1. Criminalization

Pennsylvania has attempted to bring criminal charges against at least two non-nurse midwives. Lucille Sykes, in 1989, was the first.¹⁸⁰ Diane Goslin, in 2012, was the most recent.¹⁸¹ Following Goslin’s involvement in the births of several babies who died or received inadequate treatment, Lancaster County

176. Although the Midwife Regulation Law imposes a maximum civil penalty of \$100, 63 PA. STAT. AND CONS. STAT. ANN. § 175 (West 2018), a non-nurse midwife could conceivably be assessed a \$100 fine for every prenatal visit or every birth she ever attended.

177. Cf. Fisch, *supra* note 169, at 98–99 (discussing the state of Michigan law pertaining to midwives).

178. *Id.*

179. The preceding sentences are based on anecdotes the author heard throughout her career as a CNM. A laboring patient’s medical plan will drastically differ if she states that she is coming to the hospital after laboring at home with her friend or doula as opposed to stating that she is transferring to the hospital after laboring at home because her labor attendant had concerns about the progress of the labor, the mother’s health, or the baby’s health.

180. See Huntington, *supra* note 90, at 177.

181. See generally *Grand Jury*, *supra* note 1 (reporting findings of a grand jury convened to investigate Diane Goslin’s conduct at three births). Westlaw and internet searches did not uncover any more recent criminal proceedings. It is possible that a non-nurse midwife was involved more recently in a criminal proceeding, but it was not publicized.

convened an investigating grand jury.¹⁸² The grand jury did not indict Goslin.¹⁸³

Pennsylvania has not recently attempted to pass legislation explicitly outlawing non-nurse midwifery practice. And if it did seek to outlaw non-nurse midwifery, little would change in the state.¹⁸⁴ Although new legislation could provide for stricter penalties or better enforcement,¹⁸⁵ this may ultimately be detrimental to public health because it could decrease the availability of non-nurse midwives for those who have already made a conscious decision to seek these providers, or these additional sanctions could drive the practice further underground.¹⁸⁶ The increased threat of legal action for non-nurse midwives is also not guaranteed to deter them from practicing nor to deter women from seeking their services.¹⁸⁷ Additionally, the unavailability of quality midwifery care for women who desire home birth may lead to planned unassisted childbirth,¹⁸⁸ a potentially dangerous practice.¹⁸⁹ Thus, policing non-nurse midwives via the criminal justice system or passing legislation that explicitly outlaws non-nurse midwifery practice would not solve the midwife problem.

182. Brett Hambright, *No Charges Will Be Filed Against County Midwife, but Grand Jury Urges Strict Regulation of Midwifery*, LANCASTERONLINE (Oct. 16, 2013), http://lancasteronline.com/news/no-charges-will-be-filed-against-county-midwife-but-grand/article_e33f9252-3737-5de1-990c-02b-bd9476998.html [<http://perma.cc/X6S3-NUUS>].

183. *Grand Jury*, *supra* note 1, at 45–46.

184. See *supra* Part II.D.2 for a discussion of the practical effect of the legal status of non-nurse non-nurse midwifery practice in Pennsylvania.

185. See *supra* note 106 and accompanying text for a discussion of penalties for violation of the Midwife Regulation Law. The Midwife Regulation Law leaves unclear whether an unlicensed non-nurse midwife would be subject to a single civil penalty for violating the law or whether she might be subject to a single civil penalty for every act of practicing. See 63 PA. STAT. AND CONS. STAT. ANN. § 175 (West 2018). For example, non-nurse midwives could be subject to anywhere between one fine (if a non-nurse midwife's career constituted a single, extended violation of the Midwife Regulation Law) and countless fines (if, for example, each prenatal visit or birth attended constituted a distinct violation). The compounding of these penalties could ultimately be severe.

186. See Gerard Alan Hoff & Lawrence J. Schneiderman, *Having Babies at Home: Is It Safe? Is It Ethical?*, HASTINGS CTR. REP., Dec. 1985, at 19, 25 (drawing parallels between outlawing abortion and banning home birth driving practices underground with less skilled practitioners); Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909, 949–50 (1986) (discussing that overregulation of midwives may drive the practice underground, increasing the danger); see also Kristin E. McIntosh, *Regulation of Midwives as Home Birth Attendants*, 30 B.C. L. REV. 477, 520 n.335 (1989) (quoting Hoff & Schneiderman, *supra*).

187. See, e.g., Susan Kinzie & Josh White, *Midwife Karen Carr, Convicted in Alexandria Baby's Death, Is Under Investigation in Md.*, WASH. POST (May 13, 2011), http://www.washingtonpost.com/local/midwife-karen-carr-convicted-in-alexandria-babys-death-is-under-investigation-in-md/2011/05/11/AFIrp22G_story.html?utm_term=.cab49fa2c633 [<http://perma.cc/BWV3-5VVBG>]. Despite pleading guilty to child endangerment following the death of a breech baby born at home in Virginia and being under investigation in Maryland following the death of a twin born at home, women still flock to Karen Carr, a CPM, for their births. *Id.*

188. See Anna Hickman, Note, *Born (Not So) Free: Legal Limits on the Practice of Unassisted Childbirth or Freebirthing in the United States*, 94 MINN. L. REV. 1651, 1657–59 (2010).

189. See McIntosh, *supra* note 186, at 520 (arguing that an increase in unassisted childbirth would lead to worse outcomes than non-nurse midwife attended births); Hickman, *supra* note 188, at 1670–71 (discussing that, although many believe unassisted childbirth in the United States to be more dangerous than assisted childbirth, research is lacking).

2. Regulation

Shortly after the Lancaster County investigating grand jury made its recommendations, the State Board of Medicine proposed promulgating regulations to license non-nurse midwives in Pennsylvania.¹⁹⁰ The proposed date of promulgation was fall 2013.¹⁹¹ The Department of State estimated it would take six months to one year to promulgate the regulations.¹⁹² As of the fall 2018 publication of this Comment, the State Board of Medicine has yet to promulgate these regulations.¹⁹³

Other than ignoring the issue, it would seem that the simplest solution to the midwife problem would be for the Board of Medicine to promulgate regulations under the authority of the Midwife Regulation Law. Under the Midwife Regulation Law, the practice of midwifery without a license is prohibited and will be penalized.¹⁹⁴ It grants the Board’s precursor (the State Board of Medical Examination and Licensure)¹⁹⁵ wide latitude to promulgate rules and regulations for non-nurse midwives,¹⁹⁶ but it is unclear whether the current iteration of the Board (the State Board of Medicine) has the same authority because the Boards are not statutorily identical.¹⁹⁷ Even if the State Board of Medicine has the authority to promulgate the regulations, stakeholders would need to lobby to ensure that the regulations respected their desires. It would also keep regulation of non-nurse midwives under the control of the State Board of Medicine, which is not ideal given the Board’s composition.¹⁹⁸ Non-nurse midwives, like most non-physician providers in Pennsylvania, would not be

190. See 43 Pa. Bull. 774 (Feb. 2, 2013).

191. *Id.*

192. See Bill Toland, *Proposal Makes Big Push for Pennsylvania Midwives*, PITT. POST-GAZETTE (July 26, 2013, 12:00 AM), <http://www.post-gazette.com/news/health/2013/07/26/Proposal-makes-big-push-for-Pennsylvania-midwives/stories/201307260148> [<http://perma.cc/78H8-X3JR>].

193. *Cf.* 49 PA. CODE § 18 (2018) (showing the section of the Pennsylvania Code that was supposed to be updated, but which remains unchanged).

194. 63 PA. STAT. AND CONS. STAT. ANN. §§ 171, 175 (West 2018). See *supra* Part II.C.1 for a discussion of the Midwife Regulation Law.

195. The Medical Practice Act reestablished the State Board of Medical Examination and Licensure as the State Board of Medicine. Tit. 63, § 422.3(a).

196. *Id.* § 172.

197. Compare tit. 63, § 174 (“The Secretary of Health of the Commonwealth of Pennsylvania shall appoint not more than five physicians, who shall serve as inspectors of midwives and who shall maintain close supervision over, and control and instruct such midwives, in accordance with the directions and suggestions of the Secretary of Health. The provisions of this act shall be enforced by the Secretary of Health.”), with *id.* § 422.3 (requiring that the State Board of Medicine be comprised of the commissioner, the Secretary of Health, two public representatives, and seven professional members). See also *Commonwealth v. Sykes*, No. 11 E.Q. 1989, slip op. at 8–9 (Pa. Ct. Com. Pl. Dec. 21, 1990) (“[I]t is questionable whether an effective enforcement provision for [the Midwife Regulation Law’s] licensure requirement currently exists.”). In *Goslin*, the Pennsylvania Commonwealth Court determined that the Medical Practice Act and the Midwife Practice Act are two separate statutes, not *in pari materia*. *Goslin v. State Bd. of Med.*, 949 A.2d 372, 377 & n.11 (Pa. Commw. Ct. 2008).

198. See *infra* Part IV.B.1 for a discussion of the creation of a midwifery advisory board in Pennsylvania.

guaranteed representation on their state licensing board, which could lead to more restrictive laws.¹⁹⁹ Thus using the existing statutory scheme to regulate midwives would not solve the midwife problem.

3. Litigation

Before *Goslin*, non-nurse midwives facing legal action made arguments that interpreting the Medical Practice Act to prohibit non-nurse midwifery practice infringed on the midwife's constitutional rights.²⁰⁰ Alternatively, at least one non-nurse midwife argued that such an interpretation infringed upon the rights of the religious communities that she served.²⁰¹ Pennsylvania courts have declined to address these arguments.²⁰²

Litigating the constitutional validity of the Midwife Regulation Law is not the optimal route to legalize non-nurse midwifery practice in Pennsylvania²⁰³ because it would be practically and theoretically unsuccessful. Practically, at most the litigation would invalidate the challenged law, not establish licensure for non-nurse midwives. At least, it might make the law inapplicable only to the particular facts of the case. Theoretically, either clients of non-nurse midwives or non-nurse midwives themselves could claim that restrictive non-nurse midwifery laws violate their constitutional rights.²⁰⁴

Multiple authors have opined generally that such litigation on federal constitutional grounds is unlikely to be successful,²⁰⁵ and the same is true in Pennsylvania. The text of the Pennsylvania statute and relevant case law do not

199. See *supra* notes 116–20 and accompanying text.

200. Sykes, slip op. at 3 n.4; Brief of Petitioner, Diane Goslin at 38–40, *Goslin*, 949 A.2d 372 (No. 1830 C.D. 2007).

201. Brief of Petitioner, Diane Goslin, *supra* note 208, at 38–40.

202. Sykes, slip op. at 3 n.4; see also *Goslin*, 949 A.2d at 377 (concluding without having expressly addressed the substantive constitutional issue in question).

203. See Debra Evenson, *Midwives: Survival of an Ancient Profession*, 7 WOMEN'S RTS. L. REP. 313, 328–30 (1982) (arguing that a legislative approach is preferential to a judicial approach in expanding non-nurse midwifery practice). But see Walker, *supra* note 63, at 196–97 (arguing that a constitutional challenge of the Midwife Practice Law is the best option).

204. See Chris Hafner-Eaton & Laurie K. Pearce, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 826–29 (1994); McIntosh, *supra* note 186, at 507–15 (review of cases); Christopher Rausch, *The Midwife and the Forceps: The Wild Terrain of Midwifery Law in the United States and Where North Dakota Is Heading in the Birthing Debate*, 84 N.D. L. REV. 219, 239–45 (2008) (due process, privacy, and void-for-vagueness challenges); Walker, *supra* note 63, at 191–96 (specifically addressing the Midwife Regulation Law); Whitby, *supra* note 168, at 1001–14 (review of cases); Amy F. Cohen, Note, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-To-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 851 n.4 (2005) (citing to previous discussions of whether a woman has a constitutional right to childbirth options); Joanne Rouse, Note, *Indiana's Midwifery Statute and the Legal Barriers that Will Render It Unworkable*, 48 IND. L. REV. 663, 682–85 (2015) (fundamental rights, due process, and First Amendment challenges).

205. See, e.g., Michael A. Pike, Note, *Restriction of Parental Rights to Home Births via State Regulation of Traditional Midwifery*, 36 BRANDEIS J. FAM. L. 609, 617–22 (1997) (discussing how, although regulation of non-nurse midwives makes access to home birth more difficult, it is not unconstitutional).

support an argument that Pennsylvania unconstitutionally deprives non-nurse midwives of a fundamental right: First, the text of the Pennsylvania statute allows for the practice of midwifery by *licensed* non-nurse midwives—it does not facially prohibit non-nurse midwives from practicing.²⁰⁶ Second, the Third Circuit previously upheld a New Jersey statute regulating non-nurse midwives against a substantive due process challenge after concluding that neither practicing a profession nor a patient’s choice of health care provider is a fundamental right.²⁰⁷ Therefore, precedent does not support the argument that the Midwife Regulation Law creates a “deprivation” in a way that would invoke state or federal constitutional protections, making litigation unlikely to be an effective means of addressing the midwife problem.²⁰⁸

4. Legalization

Pennsylvania legislators made unsuccessful attempts in the early 1990s to legalize non-nurse midwifery practice.²⁰⁹ Their attempts were supported by the Amish community and opposed by CNMs and medical groups.²¹⁰ Although previous attempts failed, the social and political landscapes are now different.²¹¹ If Pennsylvania explicitly legalized non-nurse midwifery, it would be following a nationwide trend.²¹²

The grand jury that failed to indict Goslin recommended that the Pennsylvania legislature address regulation of non-nurse midwives.²¹³ After acknowledging that *Goslin* stated that the Medical Practice Act did not repeal the Midwife Regulation Law, the grand jury concluded that “there appears to be no practical application” of the Midwife Regulation Law because “there are no meaningful rules or regulations currently promulgated and/or enforced concerning the practice of non-nurse midwifery pursuant to any of the Acts of the Pennsylvania Legislature.”²¹⁴ It recommended “that the Legislature consider repealing the Midwife Regulation Law of 1929 in exchange for a law that either abolishes the unlicensed practice of midwifery or provides meaningful regulation of it.”²¹⁵

206. See 63 PA. STAT. AND CONS. STAT. ANN. § 171 (West 2018).

207. *Sammon v. N.J. Bd. of Med. Exam’rs*, 66 F.3d 639, 644–45 (3d Cir. 1995).

208. See *supra* notes 206–07 and accompanying text. In *Erfer v. Commonwealth*, 794 A.2d 325 (Pa. 2002), the Pennsylvania Supreme Court recognized that equal protection under the Pennsylvania Constitution is coextensive with the that under the United States Constitution, *Erfer*, 794 A.2d at 332.

209. See, e.g., S.B. 1528, 1990 Gen. Assemb., Reg. Sess. (Pa. 1990); H.B. 2354, 1990 Gen. Assemb., Reg. Sess. (Pa. 1990); see also Huntington, *supra* note 90, at 178–79.

210. Huntington, *supra* note 90, at 178–79.

211. See *infra* Part IV.A for a discussion of the current political landscape.

212. See *CPMs Legal Status by State*, BIG PUSH FOR MIDWIVES, http://pushformidwives.nationbuilder.com/cpms_legal_status_by_state [http://perma.cc/6SFD-KEGD] (last visited Nov. 1, 2018). See *infra* Parts IV.B.1 through IV.B.5 for a discussion of how select other states have addressed the problem.

213. *Grand Jury*, *supra* note 1, at 46–47.

214. *Id.* at 5 n.2 (emphasis omitted).

215. *Id.* at 46.

Repealing and replacing the Midwife Regulation Law may be the most difficult solution, but it is the one that is in the best interest of Pennsylvanians.²¹⁶ It is a reality that non-nurse midwives attend home births in Pennsylvania, and this is unlikely to change.²¹⁷ Pennsylvania should strive to take a proactive approach regarding regulation of non-nurse midwives. It need not wait for tragedy to strike (again).²¹⁸

III. MIDWIFERY AND PUBLIC HEALTH

It is a well-established principle that it is within a state's police power to regulate if it is necessary for public health.²¹⁹ Pennsylvania is free to legislate in areas that may have a wide effect on public health as a whole.²²⁰ This Section, however, concludes that the Midwife Regulation Law does not benefit public health. Part III.A demonstrates that low-risk women can safely have out-of-hospital births attended by non-nurse midwives. Part III.B discusses how the Midwife Regulation Law was not initially passed to improve public health²²¹ and that it is unclear what particular public health concern the Midwife Regulation Law currently addresses. Part III.C concludes by arguing that, in the absence of a clear public health benefit, individual women should choose where and with whom they want to give birth.

A. *Home Birth with a Non-Nurse Midwife Is Safe for Low-Risk Women*

There currently is and may always be a dearth of high-quality evidence on the safety of home birth with a non-nurse midwife.²²² Birth is unpredictable and

216. *But see* Rachel A. D. Marquardt, Note, *Balancing Babies, Birth, and Belief: A Legal Argument Against Planned Homebirth*, 16 J. GENDER RACE & JUST. 607, 629–30 (2013) (arguing that states should refuse to recognize non-nurse midwifery as a profession). Few scholars who have considered the issue do not support the regulation of non-nurse midwives. *See, e.g., id.*

217. *See supra* notes 25–26 and accompanying text.

218. Rausch, *supra* note 204, at 248–49 (“The law does not exist solely as a reactionary entity, but as a proactive force for good.”).

219. *See Jacobson v. Massachusetts*, 197 U.S. 11 (1905); Scott Burris et al., *Federalism, Policy Learning, and Local Innovation in Public Health: The Case of the Supervised Injection Facility*, 53 ST. LOUIS U. L.J. 1089, 1105–06 (2009) (“State regulation of public health is perhaps the classic example of state police power[. . .].”).

220. *See* SCOTT BURRIS ET AL., *THE NEW PUBLIC HEALTH LAW* 136–37 (2018) (explaining the state's authority to regulate for public health).

221. *See supra* Part II.B.1 for a discussion of the context surrounding the passage of the Midwife Regulation Law.

222. *See* Ole Olsen & Jette A Clausen, *Planned Hospital Birth Versus Planned Home Birth*, COCHRANE DATABASE SYSTEMATIC REVIEWS, no. 9, 2012, at 15 (“[T]here is no strong evidence to favour either planned hospital or planned home birth for selected, low-risk pregnant women.”). This lack of evidence is a function of both research study design and the low risk of serious obstetric complications in the modern United States. Randomized controlled trials are considered the gold standard for research; however, they are not feasible for researching home birth because it is unlikely that women would wish to participate in a study where they are randomly assigned to a place of birth. *See* Zielinski et al., *supra* note 19, at 362, 370. In observational studies, statistical differences may be due to the lack of control group or some unintended bias. *See* Olsen & Clausen, *supra*, at 6–7. Even if research study design limitations were overcome, the numbers of women needed to participate in

will always involve some risk.²²³ Of the utmost concern are maternal and neonatal deaths. Some researchers have found that the neonatal death rate is higher in home births than hospital births.²²⁴ But the absolute risk of an obstetric complication for a low-risk woman (the only appropriate candidate for a home birth with a non-nurse midwife)²²⁵ is so unlikely as to be almost zero,²²⁶ so there is little to be gained in terms of safety from delivering in a hospital.²²⁷

Although the health benefits for low-risk women of delivering in a hospital are minimal, the risk of undesired medical intervention is high.²²⁸ Despite its high rate of medical intervention during childbirth, the United States performs poorly on various mortality and morbidity measures.²²⁹ Many women also face

order to demonstrate statistically significant differences in maternal and perinatal mortality would be astronomical. *See id.* at 7–8 (estimating that 100,000 women would be needed for perinatal mortality and one to two million women would be needed for maternal mortality).

223. *See* Olsen & Clausen, *supra* note 222, at 3 (“Birth can only be defined as normal in retrospect.”).

224. *See, e.g.,* Joseph R. Wax et al., *Maternal and Newborn Outcomes in Planned Home Birth vs Planned Hospital Births: A Metaanalysis*, 203 AM. J. OBSTETRICS & GYNECOLOGY, 243.e1, 243.e3 (2010) (finding a two- to threefold increase in neonatal mortality in home birth versus hospital birth). *But see, e.g.,* A de Jonge et al., *Perinatal Mortality and Morbidity in a Nationwide Cohort of 529 688 Low-Risk Planned Home and Hospital Births*, 116 BRIT. J. OBSTETRICS & GYNAECOLOGY 1177, 1179–80 (2009) (finding no significant differences in perinatal mortality and morbidity between planned home births and planned hospital births). de Jonge et al. concluded that “planning a home birth is a safe option in a country with a maternity care system, which facilitates this choice through adequate numbers of well-trained midwives who assess the appropriateness of a home birth and through a rapid transportation and an integrated referral system.” *Id.* at 1182.

225. *See* M. Kathryn Menard et al., *Levels of Maternal Care*, 212 AM. J. OBSTETRICS & GYNECOLOGY 261 (2015).

226. *See* Olsen & Clausen, *supra* note 222, at 3–4 (discussing the difficulties inherent in “proper[ly] interpret[ing] events with an extremely low probability in decision making contexts”).

227. In modern obstetric practice, the greatest obstetric complications are cord prolapse, placental abruption, shoulder dystocia, and sudden nonreassuring fetal heart tones. *Id.* at 3. It is true that cesarean delivery is recommended for cord prolapse, placental abruption, and persistent nonreassuring fetal heart tones, *id.* at 3–4, and that cesarean delivery is not available at a home birth regardless of the type of attendant, *see* Menard et al., *supra* note 225, at 261. But these complications are rare, *see* Olsen & Clausen, *supra* note 222, at 3–5, and can be monitored for by trained practitioners, and women can be transferred from home to the hospital as necessary, *see* Menard, *supra* note 225, at 3. Immediate management of a shoulder dystocia is the same in and out of the hospital. *See* Olsen & Clausen, *supra* note 222, at 4.

228. *See* Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 757–62 (2018) (discussing the existing research on the prevalence of obstetric violence).

229. *See* GBD 2015 Maternal Mortality Collaborators, *Global, Regional, and National Levels of Maternal Mortality, 1990–2015: A Systematic Analysis for the Global Burden of Disease Study 2015*, 388 LANCET 1775, 1784–93 (2016); Bradley Sawyer & Selena Gonzales, *How Does Infant Mortality in the U.S. Compare to Other Countries?*, PETERSON-KAISER HEALTH SYSTEM TRACKER (July 7, 2017), <http://www.healthsystemtracker.org/chart-collection/infant-mortality-u-s-compare-countries/#item-start> [<http://perma.cc/79W2-PZSL>]. Racial disparities in maternal and infant mortality exist; non-Hispanic white women and their babies have much lower rates of maternal and infant mortality than Hispanic, American Indian/Alaska Native, and Non-Hispanic black women. *See* Vedam et al., *supra* note 12, at 11; *Infant Mortality*, CDC (Aug. 3, 2018), <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> [<http://perma.cc/3QC8-6N3N>] (noting that integrating midwives into the health care system may reduce these disparities).

obstetric violence at the hands of health care providers.²³⁰ Obstetric violence lacks a consistent definition, but is considered “a form of gender-based violence” that describes the mistreatment that women face during labor and birth.²³¹ This mistreatment ranges from disrespect to blatant abuse: coercing women into accepting unwanted treatment, refusing to provide pain medication, refusing to provide care in childbirth, and performing unconsented-to interventions like episiotomies.²³² Obstetric violence is associated with a higher incidence of postpartum depression.²³³ Receiving care from a provider that a woman chooses in the setting that a woman chooses may decrease the likelihood that she will experience obstetric violence.²³⁴ Thus, an out-of-hospital birth with a non-nurse midwife can be a safe option for appropriate candidates and may prevent undesired medical intervention.

B. *The Midwife Regulation Law Is Unrelated to Public Health*

The Midwife Regulation Law was not passed to improve public health. It was passed in response to the midwife problem.²³⁵ Midwives posed an economic threat to the burgeoning obstetric industry.²³⁶ The law allowed the male-dominated medical profession to establish economic dominance and reinforced white male dominance over women.²³⁷ Rather than allowing women to birth with a woman (often one specifically from the same racial or ethnic group)²³⁸ in the comfort of their own home, the law forced women to birth with obstetricians in the hospital.²³⁹ A law with such a sordid past should not continue to restrict a woman’s access to the type of birth she wants.

It is unclear what public health concern the Midwife Regulation Law currently ameliorates. It cannot be that out-of-hospital birth is so unsafe that it must be prohibited, because Pennsylvania does not prohibit physicians nor CNMs from attending out-of-hospital births.²⁴⁰ Thus, the only legitimate public health concern that it might address is limiting the type of provider who attends out-of-hospital births. Yet as evidenced by the high number of illegal Pennsylvania deliveries attended by non-nurse midwives, and the state’s failure

230. See Kukura, *supra* note 228, at 757–62 (discussing the existing research on the prevalence of obstetric violence).

231. *Id.* at 763.

232. See *id.* at 728–53 (classifying the different forms of obstetric violence).

233. See Karina Junqueira de Souza et al., *Institutional Violence and Quality of Service in Obstetrics Are Associated with Postpartum Depression*, 51:69 REV. DE SAÚDE PÚBLICA 1, 9 (2017) (Braz.).

234. Cf. Kukura, *supra* note 228, at 769–71, 775–78 (discussing the impact that medicalization of childbirth and social norms have on the incidence of obstetric violence).

235. See *supra* Part II.B.1.

236. See *supra* notes 65–66 and accompanying text.

237. See BARBARA EHRENREICH & DEIRDRE ENGLISH, *WITCHES, MIDWIVES & NURSES: A HISTORY OF WOMEN HEALERS* 61–65 (2d ed. 2010).

238. See VARNEY & THOMPSON, *supra* note 29, at 10–15.

239. See *supra* notes 63–75 and accompanying text.

240. See *supra* Part II.C.2 for a discussion of the legal status of CNMs in Pennsylvania.

to regulate non-nurse midwives,²⁴¹ the Pennsylvania legislature must not view non-nurse midwives as a serious threat to public health. Additionally, the proposed statutory scheme discussed *infra* will ameliorate lingering concerns about non-nurse midwives attending out-of-hospital births in Pennsylvania.²⁴²

C. *Individual Women Should Make Their Own Health Care Decisions*

Since precluding women from deciding where and with whom they birth provides no clear benefit to the public health and empowering women to decide where and with whom they birth provides benefits (like higher rates of spontaneous vaginal birth and breastfeeding, and lower rates of obstetric intervention and some neonatal mortality and morbidity measures),²⁴³ individual women should be allowed to make those decisions for themselves. When the Midwife Regulation Law was passed, childbirth was dangerous for both mother and baby.²⁴⁴ Delivering with a midwife at home was as safe as or safer than delivering with an obstetrician in a hospital.²⁴⁵ Despite the relative safety of home delivery with a midwife, obstetricians, legislatures, and women drove childbirth into hospitals.²⁴⁶ Now, childbirth in the United States is as safe as it has ever been.²⁴⁷ This has influenced how women and society experience pregnancy and childbirth and perceptions about what an acceptable level of risk in childbirth is.²⁴⁸

Thus the Pennsylvania legislature should empower women to choose from the full range of available obstetric providers and birth locales. This would allow an individual woman to decide what she views as her greatest childbirth risk—obstetric violence, maternal mortality, neonatal mortality—and what steps she would like to take to minimize that risk. Women can make this decision without sacrificing public health.²⁴⁹

241. See *supra* notes 24–28 and accompanying text.

242. See *infra* Part IV.B.

243. Cf. Vedam et al., *supra* note 12, at 11 (reporting benefits of greater midwifery integration).

244. See *supra* notes 57–62 and accompanying text.

245. See *supra* notes 61–62 and accompanying text.

246. See *supra* Part II.B.1 for a discussion of the move of childbirth from the home to hospitals.

247. See *Achievements in Public Health*, *supra* note 57, at 849 (discussing the 90% reduction in infant mortality rate and the 99% reduction in maternal mortality rate from 1900 to 1997). Unfortunately, serious gaps in outcomes for mothers and babies persist in the United States based on race. See *Infant Mortality*, *supra* note 229. The impact of race on maternal child health is beyond the scope of this Comment.

248. See Andrew Bisits, *Risk in Obstetrics—Perspectives and Reflections*, 38 MIDWIFERY 12, 12–13 (2016); Kirstie Coxon et al., *Reconceptualising Risk in Childbirth*, 38 MIDWIFERY 1, 2 (2016) (discussing “maternity care and the culture of fear”); *How Has Childbirth Changed in This Century?*, TAKING CHARGE OF YOUR HEALTH & WELLBEING, <http://www.takingcharge.csh.umn.edu/explore-healing-practices/holistic-pregnancy-childbirth/how-has-childbirth-changed-century> [http://perma.cc/8DLQ-5VEA] (last visited Nov. 1, 2018).

249. See *supra* Part III.A for a discussion on the low absolute risk of childbirth complications in low-risk pregnancies and the minimal effect of birth location on this risk.

IV. SOLVING PENNSYLVANIA'S MODERN "MIDWIFE PROBLEM"

The goal of regulating non-nurse midwives is to ensure the safety of mothers and babies in Pennsylvania while increasing the autonomy of mothers by granting women greater access to safe providers of out-of-hospital birthing services. In order to achieve this goal, the law must simultaneously encourage competent non-nurse midwives to practice in Pennsylvania and prohibit incompetent non-nurse midwives from practicing. This may be accomplished through "sensible, relatively non-burdensome licensing requirements."²⁵⁰ What is appropriate should ultimately be a collaboration between the legislature (which represents the interests of the public at large), obstetric providers in Pennsylvania (physicians, CNMs, and non-nurse midwives), and consumers of non-nurse midwifery services.

This Section proceeds in two parts. Part IV.A generalizes the views of various stakeholders in order to contextualize the recommendations in Part IV.B. Part IV.B proposes a statutory framework for licensing non-nurse midwives in Pennsylvania. It recommends that non-nurse midwives in Pennsylvania should (1) be licensed by a newly created Midwifery Regulatory Board, (2) meet the minimum education requirements of the North American Registry of Midwives (NARM), (3) have the ability to practice without a formal collaborative agreement with a physician, and (4) be required to carry malpractice insurance like all other obstetric providers in Pennsylvania. Additionally, an exception to licensure should be made for non-nurse midwives who are members of Plain communities.

A. Stakeholders

Repealing and replacing the Midwife Regulation Law would require a concerted effort on the part of non-nurse midwives and their supporters. It would require collaboration among midwives, obstetricians, consumers, and politicians. Any proposed statutory scheme would require compromises between these various stakeholders in order to become a law. This Part examines the views of each of these stakeholders.

Possibly the largest obstacle to successful legislation regulating non-nurse midwives is midwives themselves. Non-nurse midwives and CNMs have previously struggled to collaborate, viewing themselves as members of two distinct professions and disagreeing on key aspects of non-nurse midwifery licensure.²⁵¹ In Pennsylvania, CNMs have previously spoken out against legislation to regulate non-nurse midwives.²⁵² Officially, this changed when CNMs and CPMs formed United States Midwifery Education, Regulation, and Association (US MERA) in 2013.²⁵³ US MERA is a collaboration between

250. Rausch, *supra* note 204, at 220.

251. See VARNEY & THOMPSON, *supra* note 29, at 423-43 (discussing changing relationship between CNMs and non-nurse midwives).

252. See Huntington, *supra* note 90, at 179; Ochs, *supra* note 121.

253. See *Timeline of Important US MERA Events*, U.S. MIDWIFERY EDUC. REG. & ASS'N, <http://www.usmera.org/index.php/history/> [<http://perma.cc/PZ2Q-TWZM>] (last visited Nov. 1, 2018).

CNMs and CPMs through their respective professional, educational, and certifying institutions.²⁵⁴

Midwives formed the collaboration in response to the 2010 International Confederation of Midwives (ICM) Global Standards’ goal to improve maternity care and promote normal birth.²⁵⁵ ICM’s three pillars of midwifery are education to ensure a qualified workforce, regulation of professionals, and organization of professionals.²⁵⁶ In 2015 US MERA issued *Principles for Model U.S. Midwifery Legislation & Regulation*,²⁵⁷ which influenced the statutory framework proposed in this Comment.²⁵⁸ The recommendations therein are officially endorsed by all members of US MERA.²⁵⁹ Thus it is unlikely that any member of US MERA would lobby for legislation that diverges from it.

Unofficially, there continues to be tension among midwives in Pennsylvania.²⁶⁰ One root of this tension is that Pennsylvania’s current statutory scheme for CNMs is more restrictive than US MERA recommends.²⁶¹ US MERA also excludes non-nurse midwives who are not CPMs.²⁶² Additionally, some non-nurse midwives fundamentally oppose licensure for philosophical reasons and would likely support maintenance of the status quo.²⁶³ The divergent opinions among the various types of midwives in Pennsylvania may weaken lobbying in support of legislation, but could also weaken opposition to legislation.

Historical relations between physicians and midwives were “generally . . . adversarial and competitive.”²⁶⁴ Now, the relationship is more one of “mutual

254. U.S. MIDWIFERY EDUC. REGULATION & ASS’N WORK GROUP, MEMORANDUM OF UNDERSTANDING 1–3 (2015) [hereinafter U.S. MERA, MEMO OF UNDERSTANDING], <http://www.usmera.org/wp-content/uploads/2015/07/US-MERA-MOU-5015-05.pdf> [<http://perma.cc/N3PA-J987>]. The organizations participating in US MERA are the North American Registry of Midwives (NARM), the National Association of Certified Professional Midwives (NACPM), the Midwives Alliance of North America (MANA), the Midwifery Education Accreditation Council (MEAC), the American Midwifery Certification Board (AMCB), the American College of Nurse-Midwives (ACNM), and the Accreditation Commission for Midwifery Education (ACME). *Id.* at 1.

255. *Id.* at 4.

256. *Id.*

257. U.S. MIDWIFERY EDUC. REGULATION & ASS’N, PRINCIPLES FOR MODEL U.S. MIDWIFERY LEGISLATION & REGULATION (2015) [hereinafter U.S. MERA, MODEL LEGISLATION], <http://www.usmera.org/wp-content/uploads/2015/11/US-MERALegislativeStatement2015.pdf> [<http://perma.cc/34LC-EDS3>].

258. See *infra* Part IV.B for a discussion of a proposed legislative framework for Pennsylvania.

259. See U.S. MERA, MEMO OF UNDERSTANDING, *supra* note 254, at 7 (“Statements by US MERA . . . represent[] US MERA as a whole.”).

260. This is based on discussions that the author had with CNMs and a CPM, all of whom asked to remain anonymous.

261. Compare U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 6–8 (recommending a midwifery regulatory board and recommending against a malpractice insurance requirement), with *supra* Part II.C (discussing how Pennsylvania regulates CNMs).

262. See U.S. MERA, MEMO OF UNDERSTANDING, *supra* note 254, at 1 (listing organizations that are members of US MERA).

263. See Wolfson, *supra* note 186, at 951–52.

264. Cf. VARNEY & THOMPSON, *supra* note 29, at 391 (discussing CNM-physician relations).

respect and collaboration.”²⁶⁵ Officially, obstetricians have softened their stance on out-of-hospital births attended by non-nurse midwives²⁶⁶: they previously opposed licensure of non-nurse midwives, but now the American College of Obstetricians and Gynecologists “supports the development of legislation and regulations that utilize the ICM educational standards as the baseline for midwifery education and training . . . in the United States.”²⁶⁷ US MERA’s *Principles for Model U.S. Midwifery Legislation & Regulation* complies with these standards.

Midwifery is a rare issue that crosses political borders, so legislation should have bipartisan support.²⁶⁸ Consumers of non-nurse midwifery services may be the most vocal supporters of legislation.²⁶⁹ The strength of this lobby may be limited, however, because Plain communities make up a large portion of non-nurse midwifery consumers, and their members prefer not to take part in politics.²⁷⁰ Yet members of Plain communities previously rallied in support of legislation to license non-nurse midwives.²⁷¹ Ultimately, there should be widespread support among professionals and consumers for the proposed statutory scheme discussed *infra*.

B. Proposed Statutory Scheme

Licensing of health care providers requires myriad statutory and regulatory decisions. It is beyond the scope of this Comment to explore every decision. Therefore, this Comment explores the foundational statutory decisions that a state legislature must make when it licenses non-nurse midwives. These include who will regulate the non-nurse midwife (regulatory authority), what the minimum educational requirements for a non-nurse midwife are (education requirement), and whether the non-nurse midwife requires physician oversight

265. *Cf. id.* at 401 (discussing CNM-physician relations).

266. *Compare* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: PLANNED HOME BIRTH 1 (2017), <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co697.pdf?dmc=1&ts=20180925T1356449755> [<http://perma.cc/GWY8-2X9W>] (“Women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes. These factors include . . . the availability of a [CNM, CM,] or midwife whose education and licensure meet International Confederation of Midwives’ Global Standard for Midwifery Education.”), *with* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION: PLANNED HOME BIRTH 3 (2011), <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co476.pdf?dmc=1&ts=20180925T1356449755> [<http://perma.cc/QUF7-6QSL>] (“At this time, for quality and safety reasons, [ACOG] does not support the provision of care by lay midwives or other midwives who are not certified by the American Midwifery Certification Board.”).

267. AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COLLEGE STATEMENT OF POLICY: MIDWIFERY EDUCATION AND CERTIFICATION (2014), <http://www.acog.org/-/media/Statements-of-Policy/Public/sop082.pdf?dmc=1&ts=20180822T1816312903> [<http://perma.cc/NMM8-SQCN>].

268. *See* Cohen, *supra* note 204, at 868 (discussing the political diversity of midwifery supporters).

269. *See, e.g.,* *Statements of Support*, BIG PUSH FOR MIDWIVES, http://pushformidwives.nationbuilder.com/statements_of_support [<http://perma.cc/LY32-HNG3>] (last visited Nov. 1, 2018) (statements of consumers supporting state campaigns for CPM licensure).

270. *See* Ochs, *supra* note 121.

271. *Id.*

(collaborative agreement requirement). Additionally, because of Pennsylvania’s unique circumstances, this Comment explores whether non-nurse midwives should carry malpractice insurance (malpractice requirement) and whether Plain communities should be regulated differently (Plain community exception).

The law should set minimum standards for non-nurse midwives to practice in Pennsylvania and ensure that non-nurse midwives can actually meet those standards. If the statute barred non-nurse midwives from obtaining licenses, the entire purpose of the statute would be controverted—unlicensed non-nurse midwives would remain unregulated non-nurse midwives²⁷²—and the same problems that Pennsylvania currently faces would persist.²⁷³ Harsh penalties for unlicensed midwifery practice, particularly if combined with strict licensure requirements, could push midwifery practice further underground and make non-nurse midwives reluctant to consult, collaborate with, or refer to other obstetric providers when necessary.²⁷⁴

According to NARM, thirty-one states currently license non-nurse midwives,²⁷⁵ but there is wide variation in states’ statutory and regulatory schemes.²⁷⁶ Any state legislature contemplating how to address a particular public health concern can look to what other states have done.²⁷⁷ Thus, the author performed an in-depth review of non-nurse midwifery laws in Ohio, Delaware, Vermont, and Washington. The author explored Ohio because, although Ohio’s rate of home birth is lower than Pennsylvania’s,²⁷⁸ Ohio has a high overall birth rate²⁷⁹ and (like Pennsylvania) a large Plain population.²⁸⁰ The author chose Delaware because of its geographic proximity to Pennsylvania and its relatively new legislation.²⁸¹ The author chose Vermont because it has the

272. Cf. Rouse, *supra* note 204, at 689 (discussing how Indiana’s malpractice and collaborative agreement requirements fail to meet the intended purpose of the law).

273. Cf. *id.* at 688 (discussing Indiana).

274. Cf. *id.* at 689 (discussing how Indiana’s overly restrictive regulation of non-nurse midwives may ultimately make the practice of midwifery less safe).

275. See NARM, *Current Status*, *supra* note 54.

276. See *infra* Parts IV.B.1 through IV.B.5 for a comparison of Ohio’s, Delaware’s, Vermont’s, and Washington’s non-nurse midwifery regulatory schemes.

277. It is beyond the scope of this Comment to conduct a comprehensive fifty-state survey or legal mapping study. The author chose the states discussed because they shared characteristics with Pennsylvania. See *infra* notes 278–85 and accompanying text for explanations of why each state was chosen. This discussion is limited to selected laws regulating non-nurse midwives. It is beyond the scope of this Comment to compare laws regulating non-nurse midwives and CNMs in each of the states discussed. This Part is also not intended to provide a comprehensive list of all laws regulating non-nurse midwives in each state.

278. See Martin et al., *supra* note 19, at Supplemental Table I-12. In 2015, Ohio’s home birth rate was 1.1%, as compared to Pennsylvania’s rate of 1.8%. *Id.* The national average was 1.0%. *Id.*

279. See *id.* In 2015 Ohio had the eighth-highest number of births (1,471). *Id.* Pennsylvania had the second-highest number of births (2,542). *Id.*

280. See Young Ctr. for Anabaptist & Pietist Studies, *supra* note 94. Pennsylvania has the highest Amish population (74,250), followed closely by Ohio (73,780). *Id.*

281. See Act of June 9, 2015, Ch. 33, 80 Del. Laws (codified as amended in scattered sections of DEL. CODE ANN.); see also Matt Bittle, *New Law Allows Delaware Non-Nurse Midwives To Be Licensed*, DEL. ST. NEWS (June 9, 2015), <http://delawarestatenews.net/government/new-law-allows->

highest rate of home birth in the country.²⁸² The author chose Washington because it was one of the first states to consider non-nurse midwifery legislation,²⁸³ and Midwives Alliance of North America considers Washington's laws friendly to non-nurse midwives.²⁸⁴ The author reviewed how California's and Wisconsin's statutory schemes addressed collaborative agreements because legal literature previously explored them.²⁸⁵

The following parts introduce and explain each key regulatory consideration, compare other states' approaches to the key regulatory considerations, and offer recommendations for Pennsylvania. Specifically, non-nurse midwives in Pennsylvania should (1) be licensed by a newly created Midwifery Regulatory Board, (2) meet the minimum education requirements of NARM, (3) have the ability to practice without a formal collaborative agreement with a physician, and (4) be required to carry malpractice insurance like all other obstetric providers in Pennsylvania. Additionally, an exception to licensure should be made for non-nurse midwives who are members of Plain communities.

1. Regulatory Authority

Once a state decides that it wishes to regulate a certain type of health care provider, it must determine which regulatory authority will be responsible. The administrative regulatory authority is typically empowered by the legislature to promulgate rules and regulations governing the practice and licensure of the health care provider.²⁸⁶ The governance structure of the regulatory authority is typically set out in the statute.²⁸⁷ The selected governance structure is important because regulatory board members decide which rules and regulations will be presented for comment.²⁸⁸ This power can have compounding effects on public health and the profession the board is regulating.²⁸⁹

delaware-non-nurse-midwives-to-be-licensed/ [http://perma.cc/JYR6-6HK3].

282. See Martin et al., *supra* note 19, at Supplemental Table I-12.

283. See Irene H. Butter & Bonnie J. Kay, *State Laws and the Practice of Lay Midwifery*, 78 AM. J. PUB. HEALTH 1161, 1165 (1988).

284. See *State by State*, MIDWIVES ALLIANCE N. AM., <http://mana.org/about-midwives/state-by-state> [http://perma.cc/X38S-HWD9] (last visited Nov. 1, 2018) ("There is superior language in WA for all midwives.").

285. See Fisch, *supra* note 169, at 113–15 (reviewing the legal landscape of midwifery in Wisconsin); Kathlyn Marie Happe, *Chapter 303: Is California Edging Towards a "Consultive" Relationship Between Midwives and Physicians?*, 32 MCGEORGE L. REV. 713, 721–24 (2001) (discussing existing California laws regulating midwifery); Julie Harmon, Note, *Statutory Regulation of Midwives: A Study of California Law*, 8 WM. & MARY J. WOMEN & L. 115, 129–30 (2001) (discussing a 2000 amendment to California midwifery law).

286. See, e.g., 63 PA. STAT. AND CONS. STAT. ANN. § 422.8 (West 2018) ("The board, in the exercise of its duties under this act, shall have the power to adopt such regulations as are reasonably necessary to carry out the purposes of this act.").

287. U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 6.

288. See *id.*

289. See ROBIN STRYKER, PUB. HEALTH LAW RESEARCH PROGRAM, MECHANISMS OF LEGAL EFFECT: PERSPECTIVES FROM THE LAW & SOCIETY TRADITION 9–12 (2012), <http://publichealthlawresearch.org/sites/default/files/downloads/resource/Stryker-LawSociety-10April2012.pdf> [http://perma.cc/L8NJ-WAV4] (discussing organizational legalization).

Any licensing board is unable to achieve 100% enforcement. Enforcement of indiscretions that happen in the privacy of one’s home, like home birth, offers additional challenges.²⁹⁰ Threat of punishment tends to work poorly to achieve enforcement.²⁹¹ Rather, self-regulation—the willingness of the health care provider to consent and comply with prescribed regulations—is imperative to the success of these laws, and organizational legitimacy is integral to compliance.²⁹² One must believe she has an obligation to authorities and trust the legal authority, and she may view an organization as more legitimate if she feels that she has a voice in the organization and that the organization treats her with respect.²⁹³ Non-nurse midwives in Delaware, Vermont, and Washington are all licensed with input from midwifery regulatory boards rather than a board of medicine.²⁹⁴

The statute should establish a Midwifery Regulatory Board to promulgate regulations to license non-nurse midwives and handle disciplinary proceedings. The Board should comprise primarily of non-nurse midwives, but also have at least one CNM, one obstetrician, and one pediatrician. This is in line with what other states have done²⁹⁵ and what US MERA advocates.²⁹⁶ Having a Midwifery Regulatory Board would likely increase compliance with licensure requirements.²⁹⁷ This is particularly important because non-nurse midwives in Pennsylvania who are currently practicing without licenses or board oversight may not have an incentive to seek licensure. This portion of the statute may face opposition from CNMs who are currently regulated under the Board of Medicine.²⁹⁸ A potential solution is to have the Midwifery Regulatory Board license all kinds of midwives in Pennsylvania.

290. See TOM R. TYLER & AVITAL MENTOVICH, PUB. HEALTH LAW RESEARCH PROGRAM, MECHANISMS OF LEGAL EFFECT: THEORIES OF PROCEDURAL JUSTICE 10 (2011), <http://publichealthlawresearch.org/sites/default/files/downloads/resource/TylerMethodsMonograph.pdf> [<http://perma.cc/Z7TD-ZGP7>].

291. See *id.*

292. See *id.* at 10–11 (discussing the connection between perceived legitimacy and compliance with public health laws).

293. See *id.* at 2 (discussing the components of procedural fairness).

294. See DEL. CODE. ANN. tit. 24, § 1799HH (West 2018); VT. STAT. ANN. tit. 26, § 4185(c) (West 2018); WASH. REV. CODE ANN. § 18.50.140 (West 2018). Delaware has a seven-member Midwifery Advisory Council that comprises two certified midwives (CMs), two CPMs, one CNM, one obstetrician, and one pediatrician. DEL. CODE. ANN. tit. 24, § 1799HH(a). The Midwifery Advisory Council “shall promulgate rules and regulations . . . subject to the approval of the Board of Medical Licensure and Discipline.” *Id.* § 1799HH(c). Vermont has a six-member advisory committee that comprises three CPMs, two physicians, and one CNM. See VT. STAT. ANN. tit. 26, § 4185(c)(2). Washington has a seven-member midwifery advisory committee that comprises one obstetrician, one physician, one CNM, three midwives, and one disinterested public member. WASH. REV. CODE ANN. § 18.50.140.

295. See *supra* note 294 and accompanying text.

296. U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 6.

297. See *supra* notes 290–93 and accompanying text.

298. See *supra* Part II.C.2 for a discussion of the regulation of CNMs in Pennsylvania.

2. Education Requirement

Non-nurse midwifery education requirements are fairly uniform across the states. As of 2015, twenty-six states tied their minimum education requirement for licensure to the education requirements to become a CPM.²⁹⁹ Delaware requires that CPMs have at least a high school education and “[m]eet minimum educational requirements as required for attainment of the CPM credential.”³⁰⁰ Vermont and Washington require that non-nurse midwives have at least a high school education.³⁰¹ Additionally, Washington requires that non-nurse midwives attend an accredited midwifery program at least three years in length.³⁰²

The statute should require that non-nurse midwives meet NARM’s minimum educational requirements.³⁰³ This is supported by obstetricians,³⁰⁴ CNMs, CPMs,³⁰⁵ and legal scholars.³⁰⁶ This educational requirement would preclude non-nurse midwives who are not CPMs from being licensed in Pennsylvania. This is desirable.

Licensure allows a consumer to quickly realize whether her provider meets certain minimum qualifications. Non-nurse midwives who are not CPMs are too varied in their level of education and experience to meet this goal. There must be some standards in place in order for regulation to have any meaning. Some stakeholders may be concerned that a Plain midwife’s compliance with these educational requirements might violate her religious tenets. These concerns are addressed below.³⁰⁷

3. Collaborative Agreement Requirement

Collaborative agreements provide a mechanism for states to restrict a non-

299. Rouse, *supra* note 204, at 675–76. See also *supra* Part II.A.2 for a discussion of the CPM credential.

300. DEL. CODE ANN. tit. 24, § 1799II(a)(5)–(6) (West 2018).

301. VT. STAT. ANN. tit. 26, § 4183(2) (West 2018). Vermont does not explicitly state that non-nurse midwives need education beyond a high school education, but because Vermont only licenses non-nurse midwives who are CPMs, all licensed non-nurse midwives in Vermont meet the minimum educational requirements to be a CPM. *See id.* § 4183(1).

302. WASH. REV. CODE ANN. § 18.50.040(2)(a) (West 2018). The statute then delineates minimum educational requirements that must be met by the midwifery program. *Id.* § 18.50.040(2)(b). There is also a requirement that the non-nurse midwife participate in at least fifty deliveries and observe at least fifty deliveries. *Id.* § 18.50.040(2)(c).

303. *See* NARM CPM CIB, *supra* note 47, at 6. See also *supra* Part II.A.2 for a discussion of those minimum educational requirements.

304. *ACOG Statement on the US MERA Bridge Certificate*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 14, 2016), <http://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-the-US-MERA-Bridge-Certificate> [<http://perma.cc/UMX4-BRPQ>] (“ACOG supports the International Confederation of Midwives (ICM) educational standards as the minimum education and licensure requirement for all midwives practicing in the US.”).

305. U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 6–7.

306. *See* Rausch, *supra* note 204, at 249–50; Storck, *supra* note 66, at 105–06 (characterizing Ohio’s proposition to conform with the NARM standard as a “reasonable and well-developed response”).

307. *See infra* Part IV.B.5 for discussion of a Plain community exception.

nurse midwife’s scope of practice by imposing a supervisory relationship between the non-nurse midwife and a physician.³⁰⁸ When a non-nurse midwife practices without a collaborative agreement, her scope of practice is limited only by her education, certification, and experience.³⁰⁹ Non-nurse midwives are trained (and CPMs are certified) to manage normal pregnancies and deliveries.³¹⁰ Thus, even in the absence of a collaborative agreement requirement, a non-nurse midwife is still limited to caring for *low-risk* pregnant women.³¹¹

Proponents of written collaborative agreements believe that they protect public health by preventing unqualified health care providers from practicing.³¹² Opponents of collaborative agreements believe that their purpose is only to serve as anticompetitive restrictions, which harm public health by exacerbating shortages of maternity care providers and contributing to the high cost of maternity care in the United States.³¹³

Results of research conducted on CNMs are mixed on whether autonomous practice³¹⁴ results in more midwives.³¹⁵ Results are also mixed on whether autonomous practice improves maternal or neonatal outcomes,³¹⁶ but they do *not* demonstrate detrimental maternal or neonatal outcomes.³¹⁷ Less-restrictive CNM laws are associated with a significant increase in the use of CNMs.³¹⁸ Malpractice rates may decrease for physicians in states that abolish collaborative agreements.³¹⁹

308. ACOG, COLLABORATIVE PRACTICE, *supra* note 113, at 17–18.

309. *Id.*

310. See *supra* Part II.A.2 for a description of the CPM credential.

311. See Menard et al., *supra* note 225, at 261–68. The lowest risk delivery is an uncomplicated, singleton, vertex (head down) fetus at term (between thirty-seven and forty-two weeks) with a mother who does not have a history of Cesarean delivery. *Id.* at 261.

312. See, e.g., *Scope of Practice*, AM. MED. ASS’N, <http://www.ama-assn.org/about/scope-practice> [<http://perma.cc/NZN7-9KD7>] (last visited Nov. 1, 2018).

313. See Benjamin J. McMichael et al., *The Extraregulatory Effect of Nurse Practitioner Scope-of-Practice Laws on Physician Malpractice Rates*, 75 MED. CARE RES. & REV. 312, 313–17 (2017) (discussing the debate over scope-of-practice laws for nurse practitioners); Rouse, *supra* note 204, at 689 (discussing how collaborative agreements can be a bar for licensure for non-nurse midwives).

314. Autonomous practice is when a state law allows a licensed provider to practice without a collaborative agreement. See ACOG, COLLABORATIVE PRACTICE, *supra* note 113, at 17–19.

315. Compare Y. Tony Yang et al., *State Scope of Practice Laws, Nurse-Midwifery Workforce, and Childbirth Procedures and Outcomes*, 26 WOMEN’S HEALTH ISSUES, 262, 266 (2016) (suggesting that autonomous midwifery practice is associated with an increased midwifery workforce), with Sara Markowitz et al., *Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?*, 55 J. HEALTH ECON. 201, 216–17 (2017) (finding little effect on the level of employment of CNMs).

316. Compare Yang et al., *supra* note 326, at 266 (suggesting that autonomous midwifery practice is associated with improved outcomes), with Markowitz et al., *supra* note 326, at 216–17 (finding little effect on outcomes). The outcomes explored by the Yang study were cesarean delivery rate, preterm birth, and low birthweight. Yang et al., *supra* note 326, at 266.

317. See Markowitz et al., *supra* note 326, at 216–17 (“Our results point to the conclusion that removing barriers on the CNM practice will not harm mothers or their infants, and that the restrictive laws primarily serve as artificial barriers to care.”).

318. *Id.* at 217.

319. Cf. McMichael et al., *supra* note 322, at 313 (examining nurse practitioners).

The states examined are not uniform in their approach to collaborative agreements between non-nurse midwives and physicians. Delaware requires that non-nurse midwives establish a “collaborative agreement”³²⁰ with “a Delaware licensed physician with obstetrical hospital privileges.”³²¹ At a minimum, the collaborative agreement must indicate “a minimum number of medical provider prenatal visits [and] . . . guidelines and protocols that must include access and use of oxygen, medications (including Intravenous medications), emergency protocols for labor, delivery, and postpartum for both mother and neonate.”³²² Vermont requires CPMs to have “a written plan for consultation” with a Vermont-licensed physician “for transport of an infant to a newborn nursery or neonatal intensive care nursery, and for transport of a woman to an appropriate obstetrical department or patient care area.”³²³ Washington requires that “[e]very licensed midwife shall develop a written plan for consultation with other health care providers, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive care nursery, and transport of a woman to an appropriate obstetrical department or patient care area.”³²⁴

California, one of the first states to explicitly legalize non-nurse midwifery, originally included a requirement for non-nurse midwives to have a collaborative agreement with a physician.³²⁵ This proved to be a legal barrier to practice,³²⁶ and California amended its non-nurse midwifery statute to remove the collaborative agreement requirement.³²⁷

CNMs in states (like Pennsylvania) that impose a collaborative agreement requirement on CNMs are often opposed to treating non-nurse midwives, who have less formal training, differently.³²⁸ Wisconsin employed a unique approach to address this problem. There, “CNMs have the opportunity to transform their legal status to that of a [non-nurse midwife]. . . . This allows CNMs to become [non-nurse midwives] in order to practice independently without requiring physicians to discard supervision requirements for continuing CNMs.”³²⁹

Non-nurse midwives in Pennsylvania should not be required to have a

320. A collaborative agreement is “[w]ritten verification of health care facility approved clinical privileges; or health care facility approved job description; or a written document that outlines the process for consultation and referral between a direct entry/non-nurse midwife and a Delaware licensed physician with obstetrical hospital privileges.” 16-4000-4106 DEL. ADMIN. CODE § 3.0 (2018).

321. *Id.* § 4.3.

322. *Id.*

323. VT. STAT. ANN. tit. 26, § 4190(a) (West 2018).

324. WASH. REV. CODE ANN. § 18.50.108 (West 2018).

325. Happe, *supra* note 293, at 722.

326. *Id.* (noting that between 1993 and 2001, 111 non-nurse midwives became licensed in California, but only one could find a collaborating physician).

327. See Act of Sept. 1, 2000, Ch. 303, §§ 1–2, 2000 Cal. Stat. 2599, 2599–600 (current version at CAL. BUS. & PROF. CODE § 2508) (repealing and replacing the section of the Licensed Midwifery Practice Act of 1993 that required collaborative agreements); see also Harmon, *supra* note 293, at 129.

328. This is based on discussions that the author had with CNMs and a CPM, all of whom asked to remain anonymous.

329. Fisch, *supra* note 169, at 114; see also WIS. STAT. ANN. § 440.982(1) (West 2018) (statute discussed by Fisch).

written collaborative agreement with a physician in order to get a license. A written collaborative agreement requirement would likely be an absolute bar to licensure for many non-nurse midwives.³³⁰ Midwives who serve rural areas that may lack obstetric providers may find it even more difficult to secure the necessary collaborative agreement, further straining access to obstetric care in these underserved areas.³³¹ And Pennsylvania’s modern midwife problem would persist.³³²

There is no evidence that written collaborative agreements improve outcomes.³³³ This is in line with what some other states have done,³³⁴ US MERA’s recommendations,³³⁵ and legal scholarship on the issue.³³⁶ The lack of a collaborative agreement requirement does not mean that there would be no oversight of non-nurse midwives. Non-nurse midwives would still have to meet the minimum education requirements and their scope of practice would be limited to what is appropriate based on their education, knowledge, and experience. The lack of a collaborative agreement also does not mean a lack of collaboration between non-nurse midwives and other health care providers. Non-nurse midwives need physicians and hospitals willing to accept transferred clients,³³⁷ which can be done on an informal basis.³³⁸ Licensed non-nurse midwives practicing legally could also become members of health care teams.³³⁹

CNMs in Pennsylvania are required to have a written collaborative agreement.³⁴⁰ This could mean that CNMs in Pennsylvania would not support legislation that allowed non-nurse midwives to practice without a written collaborative agreement while CNMs must. Pennsylvania could address this by

330. See *supra* notes 325–27 and accompanying text. In a conversation with the author, an anonymous CPM who practices in Pennsylvania opined that she is the only non-nurse midwife she knows who could find a physician with whom to enter into a written collaborative agreement.

331. Cf. Rouse, *supra* note 204, at 690 (discussing the potential impact of Indiana’s collaborative agreement requirement on the practice of non-nurse midwives).

332. See *supra* Part II.D for a discussion of the current status of midwives in Pennsylvania); cf. Rouse, *supra* note 204, at 691 (“[T]he result of [Indiana’s] collaboration requirement will be a large number of midwives practicing illegally, who are not subject to the standard of care as outlined in the statute and who will avoid any sort of relationship with physicians. The midwifery community will continue to be on the fringe of the maternal health community, much like when [non-nurse midwifery] was illegal.”).

333. See *supra* notes 314–19 and accompanying text.

334. See *supra* notes 320–29 and accompanying text.

335. U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 6.

336. See, e.g., Rausch, *supra* note 204, at 251–52 (“Due to the possibility of the misuse of physician supervision and the heavy burden of finding a physician willing to enter into a supervisory relationship, legislation could be drawn up that would eliminate supervision requirements entirely.”).

337. Cf. Menard et al., *supra* note 225, at 261–65 (discussing levels of maternal care); Vedam et al., *supra* note 12, at 2–3 (discussing the importance of midwifery integration).

338. See, e.g., Maryland Licensure of Direct-Entry Midwives Act, Ch. 529, 2018 Md. Laws (codified as amended at MD. CODE ANN., HEALTH OCC. §§ 8-6C-03 to -04, -07 to -10, -13) (amending non-nurse midwifery laws with no collaborative agreement requirement).

339. See, e.g., *Our Midwives*, ANDALUZ WATERBIRTH CTR., <http://www.waterbirth.net/our-midwives/> [<http://perma.cc/NVW6-8EK9>] (last visited Nov. 1, 2018) (employing CPMs and CNMs).

340. See *supra* notes 112–15 and accompanying text.

including language in the statute like Wisconsin does, giving CNMs the option to be governed by the non-nurse midwife statutory requirements with a more limited scope of practice.³⁴¹ A superior option would be to remove the written collaborative agreement for CNMs as well.

4. Malpractice Insurance Requirement

The risk of facing a malpractice suit as a health care provider for women and babies is high and continues to rise.³⁴² Malpractice suits for physicians and CNMs are not an uncommon occurrence.³⁴³ The same reasons that CNMs face malpractice suits exist for non-nurse midwives too.³⁴⁴ Obstetricians have an above-average risk of facing a malpractice suit.³⁴⁵ It is more likely that a plaintiff in an obstetric malpractice suit will be indemnified, and those payments tend to be higher than in other specialties.³⁴⁶

It is uncommon for non-nurse midwives to carry malpractice insurance.³⁴⁷ Research is lacking to conclude whether this is because non-nurse midwives do not want insurance, cannot access affordable insurance, or do not need it because they do not face malpractice suits. Regardless of the reason, this lack of malpractice insurance may impact whether physicians are willing to consult with, collaborate with, or accept referrals from non-nurse midwives due to fears that they may become the target of malpractice suits simply because the physicians are insured.³⁴⁸

Alternatively, non-nurse midwives may not want insurance because if they are found liable for malpractice but lack coverage, they can file for bankruptcy, leaving victims uncompensated.³⁴⁹ Non-nurse midwives who desire malpractice

341. See *supra* note 329 and accompanying text.

342. See William F. McCool et al., *Closed Claims Analysis of Medical Malpractice Lawsuits Involving Midwives: Lessons Learned Regarding Safe Practices and the Avoidance of Litigation*, 60 J. MIDWIFERY & WOMEN'S HEALTH 437, 437–38 (2015).

343. See Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629, 629 (2011) (finding that 7.4% of physicians per year have a malpractice claim and 1.6% of claims lead to payment); McCool et al., *supra* note 342, at 437–38 (summarizing surveys reporting that 25 to 35% of CNMs have been involved in a malpractice suit). This author could not find any studies examining the malpractice claim rate of non-nurse midwives.

344. See McCool et al., *supra* note 342, at 439–41 (noting that for CNMs some of the most common categories of intrapartum risk are fetal or newborn complications, shoulder dystocia, and failure to assess need for a cesarean). Based on the author's experience, the potential for those complications exist at every birth.

345. See Jena et al., *supra* note 343, at 632.

346. See *id.* at 632–33 (finding that obstetricians have the highest payment rate: greater than 38% of malpractice claims). This study did not distinguish between settlement payments and jury awards. See *id.*

347. See Lusero, *supra* note 12, at 427–29 (discussing how structural factors influence non-nurse midwives' decisions regarding malpractice insurance).

348. See Joseph W. Booth, *An Update on Vicarious Liability for Certified Nurse-Midwives/Certified Midwives*, 52 J. MIDWIFERY & WOMEN'S HEALTH 153, 156 (2007) (discussing that a plaintiff is more likely to litigate under a theory of vicarious liability if the closest health care provider is unable to adequately compensate for damages); Lusero, *supra* note 12, at 427–29.

349. See Louise Knott Ahern, *Couple Awarded \$5 Million After Botched Midwife Delivery*,

insurance may have trouble finding a provider, or the cost may be prohibitive for her small-volume practice.³⁵⁰

It may be that neither non-nurse midwives nor their patients require malpractice insurance. Non-nurse midwives foster communication with their clients and promote active involvement in the health care decision-making process, which is associated with a reduction in liability.³⁵¹ Because non-nurse midwifery care in an out-of-hospital setting is considerably less expensive than care in a hospital with an obstetrician, “[i]n a sense, patients are choosing not to pay the costs of providers’ liability insurance premiums up front . . . in exchange for forgoing extensive damages in the event of negligence.”³⁵² Many non-nurse midwives in Pennsylvania provide care to the Plain population where families are unlikely to bring malpractice suits.³⁵³ Patients may also choose to sue providers or facilities that assume care after the transfer rather than the non-nurse midwife.³⁵⁴ It is unclear whether this is due to a higher likelihood of recovery or because patients do not want to sue non-nurse midwives.

Of the states examined, none impose a requirement that non-nurse midwives carry malpractice insurance but most require that non-nurse midwives disclose this fact to their patients. Delaware requires CPMs to disclose whether they carry malpractice insurance.³⁵⁵ Delaware provides several explicit protections from vicarious liability for physicians who work with CPMs. The first protection is the requirement that the informed consent from the patient includes “[a]n explanation that in the event of an emergency or voluntary transfer that no liability from the actions of the midwife are assignable to the receiving facility or medical professional.”³⁵⁶ The second protection is the inclusion of the following provision: “No health-care provider or facility shall be vicariously liable for an injury resulting from an act or omission by a midwife unless an employment and/or agency relationship has been established between the midwife and the health-care provider or facility.”³⁵⁷

Vermont requires CPMs to disclose whether they have professional liability

USA TODAY (May 27, 2014, 7:18 AM), <http://www.usatoday.com/story/news/nation/2014/05/27/lawsuit-botched-midwife-delivery/9618243/> [<http://perma.cc/3SUK-YDZK>] (noting that a couple that was awarded \$5 million in damages after a “botched midwife delivery” was “unlikely . . . [to] collect any money because [the midwife] did not carry malpractice insurance”).

350. See WASH. REV. CODE ANN. § 48.87.010 (West 2018) (“In particular midwives practicing outside hospital settings are unable to obtain malpractice insurance at any price in this state at this time.”); Lusero, *supra* note 12, at 427–29.

351. Fisch, *supra* note 169, at 109.

352. *Id.* at 110.

353. Laura Ballou, *Amish Medicinal Beliefs, Practices, and Practitioners: Medical Hegemony and Its Role in Amish Medical Decision-Making*, 24 HIGH PLAINS APPLIED ANTHROPOLOGIST 174, 177 (2004).

354. See, e.g., Meredith Cohn, *Details on Midwife Unaired in Hopkins Malpractice Case*, BALTIMORE SUN (July 14, 2012, 6:17 PM), <http://www.baltimoresun.com/health/maryland-health/bs-hs-hopkins-malpractice-midwife-20120713-story.html> [<http://perma.cc/8CHT-3DKT>].

355. DEL. CODE ANN. tit. 24, § 1799JJ(2)(h) (West 2018).

356. *Id.* § 1799JJ(2)(e).

357. *Id.* § 1799KK(a).

insurance coverage.³⁵⁸ Washington does not require that midwives have malpractice insurance, but recognizes that affordable malpractice insurance should be made available to midwives.³⁵⁹ To accomplish that, Washington established “a nonprofit, joint underwriting association for midwifery and birth center malpractice insurance.”³⁶⁰

Non-nurse midwives in Pennsylvania should be required to carry malpractice insurance like all other licensed obstetric providers in the Commonwealth.³⁶¹ The statute should also explicitly state that obstetricians and hospitals that accept transfers from non-nurse midwives cannot be held vicariously liable for the actions of the non-nurse midwife. This will provide protection for non-nurse midwives and their clients. Obstetrics is a high-risk malpractice field and the most common sources of suits exist for non-nurse midwives, just as they do for other types of providers.³⁶² It is unclear whether non-nurse midwives face malpractice suits with the same frequency, but this could be because most of them do not currently carry malpractice insurance and can file for bankruptcy if a judgment attaches, essentially making them judgment-proof.³⁶³

A malpractice insurance requirement provides a means to compensate harmed parties. Protecting against vicarious liability for obstetricians and hospitals that accept transferred patients eliminates the risk of non-nurse midwifery care increasing health care costs for the public.³⁶⁴ In fact, out-of-hospital care with a non-nurse midwife is considerably less expensive than traditional obstetric care.³⁶⁵ The cost-savings of out-of-hospital births remain even when the birth attendant carries malpractice insurance.³⁶⁶

Imposing a malpractice insurance requirement is not in line with what other states have done,³⁶⁷ but the existence of the MCARE Act is strong evidence of the Pennsylvania legislature’s intent for certain types of health care providers in

358. VT. STAT. ANN. tit. 26, § 4191 (West 2018).

359. WASH. REV. CODE ANN. § 48.87.010 (West 2018).

360. *Id.* § 48.87.030. A non-nurse midwife with at least one year of experience pays a base rate of \$6,867 per year for coverage from the association. *Premium Guidelines*, WASH. ST. MIDWIFERY & BIRTHING CTR. MED. MALPRACTICE JOINT UNDERWRITING ASS’N, <http://washingtonjua.com/rates.htm> [<http://perma.cc/F9KQ-TDCM>] (last visited Nov. 1, 2018). This base rate includes coverage for twelve births. *Id.* Births beyond twelve are paid on a per birth basis at a rate of \$130 to \$198 per birth. *Id.*

361. 40 PA. STAT. AND CONS. STAT. ANN. § 1303.711(a) (West 2018); *see* 49 PA. CODE § 16.32(a) (2018).

362. *See* McCool et al., *supra* note 342, at 437–38.

363. *See supra* notes 347–53 and accompanying text.

364. *See supra* notes 349–54 and accompanying text. *But see* Michelle M. Mello et al., *National Costs of the Medical Liability System*, 29 HEALTH AFFAIRS 1569, 1574–75 (2010) (estimating that the medical liability system accounts for 2.4% of health care spending).

365. *See* Sally K. Tracy & Mark B. Tracy, *Costing the Cascade: Estimating the Cost of Increased Obstetric Intervention in Childbirth Using Population Data*, 110 BJOG 717, 717 (2003).

366. *Cf. id.* at 719–21 (reporting results of a study examining the costs of obstetric interventions).

367. *See supra* notes 355–60 and accompanying text.

Pennsylvania to carry malpractice insurance.³⁶⁸ This requirement would likely be unpopular with non-nurse midwives who are concerned that the high cost of malpractice insurance might serve as a bar to licensure.³⁶⁹ CNMs would likely have mixed feelings about this requirement. On the one hand, it could be unpopular with CNMs for non-nurse midwives to have fewer bars to licensure than CNMs in the same state. On the other hand, CNMs are part of US MERA, which rejects imposing a malpractice insurance requirement upon non-nurse midwives.³⁷⁰ A malpractice requirement would likely be popular with obstetricians who might be concerned about vicarious liability.³⁷¹ The proposed statutory scheme is intended to represent a compromise among stakeholders, which necessitates that not all parties will get exactly what they want. Additionally, the legislature could (and should) address concerns that a malpractice requirement might bar non-nurse midwives from licensure, but the best method to do so is beyond the scope of this Comment.

5. Plain Community Exception

Pennsylvania’s large Plain population and their preference for out-of-hospital birth necessitates consideration of Plain communities in any legislation addressing non-nurse midwifery. There are many factors that influence the Plain preference for out-of-hospital birth, but there is no specific religious tenet that prevents Plain communities from seeking medical care in a hospital with an obstetrician.³⁷² Rather, Plain communities’ values create obstacles to traditional obstetric care that out-of-hospital birth can alleviate. As most members of this community do not carry traditional health insurance, cost is a driving factor.³⁷³ Transportation can also impede access to prenatal care and hospital birth.³⁷⁴ Therefore, failing to provide access to non-nurse midwifery care or out-of-hospital birth does not directly infringe on Plain communities’ religious liberty,³⁷⁵ but may limit their access to health care.

Data on who is providing birth services to Plain communities are difficult to ascertain,³⁷⁶ but many of the providers are not members of Plain communities,

368. See *supra* note 96 and accompanying text.

369. U.S. MERA, MODEL LEGISLATION, *supra* note 257, at 8 (recommending that midwifery regulation not require midwives to purchase professional liability insurance).

370. See *id.*

371. See Booth, *supra* note 348, at 156; cf. Susan M. Jenkins, *The Myth of Vicarious Liability: Impact on Barriers to Nurse-Midwifery Practice*, 39 J. NURSE-MIDWIFERY 98, 102 (1994) (discussing CNMs).

372. See Ballou, *supra* note 353, at 177 (“[T]here are no specific rules in the Ordnung that regulate medical care . . .”).

373. See Huntington, *supra* note 90, at 172; Interview with Sarah Beebe, MSN, CNM, WHNP-BC, Instructor, Univ. of Del., in Wilmington, Del. (Nov. 7, 2017) [hereinafter Beebe Interview].

374. Karla Campanella et al., *Pregnancy and Childbirth Among the Amish*, 36 SOC. SCI. & MED. 333, 336–37 (1993); Beebe Interview, *supra* note 373.

375. But see Brief of Petitioner, Diane Goslin, *supra* note 208, at 38–40 (arguing that the Old Order Amish’s religious beliefs necessitate home birth).

376. See Kirk Miller et al., *Health Status, Health Conditions, and Health Behaviors Among Amish Women: Results from the Central Pennsylvania Women’s Health Study (CePAWHS)*, 7

and many of them are not non-nurse midwives.³⁷⁷ It is unclear how many members of Plain communities provide non-nurse midwifery services to their communities, but it is likely to be more than zero.³⁷⁸ The requirement to carry malpractice insurance might infringe on a Plain non-nurse midwife's religious liberty.³⁷⁹

Ohio, which does not license non-nurse midwives,³⁸⁰ has dealt with the desires of religious communities regarding birthing practices in an interesting way. Ohio licenses "freestanding birthing center[s]" as a type of "[h]ealth care facility."³⁸¹ Ohio's director of health must "establish quality standards," which may include "accreditation standards," for these freestanding birth centers.³⁸² But, freestanding birth centers that are owned and operated by a "religious denomination, sect, or group" are exempt from this licensure requirement if "[r]equiring that the center be licensed significantly abridges or infringes on the religious practices or beliefs of that religious denomination, sect, or group" and "[t]he center provides care only during low-risk pregnancy, delivery, and the immediate postpartum period *exclusively* to women who are members of that religious denomination, sect, or group."³⁸³ While a license is not required, these exempt centers must "monitor[] and evaluate[] the care provided to [their] patients" and "meet[] . . . quality assessment and improvement standards."³⁸⁴ Administrative guidelines impose additional requirements in order for a freestanding birth center to be exempt from the licensure requirement.³⁸⁵

Pennsylvania's large Plain communities necessitate an exception from licensure for non-nurse midwives like Ohio has for freestanding birth centers.³⁸⁶ This will ensure that the religious rights of members of Plain communities are not infringed upon. This exemption would not negate the remainder of the regulation because non-nurse midwives in non-Plain communities seeking credibility would desire licensure.³⁸⁷ The exception should be limited to Plain non-nurse midwives providing services in Plain communities. It should not extend to any non-nurse midwife providing services in Plain communities.

WOMEN'S HEALTH ISSUES 162, 163 (2007).

377. Beebe Interview, *supra* note 373 (noting that in addition to Birth Care & Family Health Services, there are at least three CNM groups and a physician providing home birth services in Lancaster County).

378. *Cf.* Huntington, *supra* note 90, at 172–75 (discussing Amish midwives in Ohio).

379. *Cf. id.* at 172 (discussing religious objection to insurance). See also *supra* notes 372–75 and accompanying text for a brief overview of Plain religious beliefs that influence homebirth).

380. See OHIO REV. CODE ANN. § 4723.03 (West 2018) (discussing licensure of nurses, CNMs, and advanced practice nurses without mentioning non-nurse midwives).

381. *Id.* § 3702.30(A)(4)(d).

382. *Id.* § 3702.30(B).

383. *Id.* § 3702.301(A)(1)–(3) (emphasis added).

384. *Id.* § 3702.301(A)(4)–(5).

385. See OHIO ADMIN. CODE 3701-83-08 (West 2018).

386. See OHIO REV. CODE ANN. § 3702.301(A); *cf.* Storck, *supra* note 66, at 106 (discussing Ohio's large Plain communities).

387. *Cf.* Storck, *supra* note 66, at 106 (arguing the same in Ohio).

IV. CONCLUSION

Pennsylvania should repeal and replace the Midwife Regulation Law because the current non-nurse midwifery regulatory scheme is detrimental to public health. This Comment proposed a statutory framework for new legislation providing licensure for non-nurse midwives. The framework is designed to ensure that licensed non-nurse midwives in Pennsylvania are adequately qualified without imposing such strict requirements that non-nurse midwives cannot realistically meet them. This balance will ensure that Pennsylvania’s mothers and babies remain safe while maximizing individual autonomy.

Regulations that narrowly circumscribe who attends a woman’s birth and where it occurs strip individual women of their agency to determine what constitutes an acceptable level of risk in childbirth. It also reflects a societal determination that the small absolute risk to mother or baby from having unlimited childbirth choices is more legitimate and harmful than the high likelihood of undesired medical intervention. Individual autonomy, with reasonable government oversight, should prevail when the evidence is unclear.³⁸⁸ Women themselves—not male-dominated legislatures—are the appropriate decision makers when the likelihood of an event is small, like in a home birth with a non-nurse midwife who meets the qualifications of the proposed statute.³⁸⁹

388. See Cohen, *supra* note 204, at 862 (arguing that it is irrelevant “*which* choice is correct, but that given the fact that medical science has so often been wrong and that these choices are of such personal importance and value-laden, it is the *individual who should choose*”). *But see* Marquardt, *supra* note 216, at 632–33 (arguing that while autonomy in birthing decisions is important, CNMs and hospital birth centers adequately protect this autonomy).

389. See, e.g., Cohen, *supra* note 204, at 880 (“[A]bsent a showing of incompetence, a mother-to-be should be authorized to make joint health decisions for herself and the developing child, as she would be moments after birth.”).