

TEMPLE LAW REVIEW

© 2020 TEMPLE UNIVERSITY OF THE COMMONWEALTH SYSTEM OF
HIGHER EDUCATION

VOL. 93 NO. 2

WINTER 2021

ARTICLES

BETTER BIRTH

*Elizabeth Kukura**

ABSTRACT

Although the recent focus on maternal mortality has highlighted the problem of poor health outcomes for childbearing women and their babies, especially in communities of color, adverse outcomes are only one of many indications that mainstream maternity care often fails pregnant people and their families. Other signs that maternity care reform is desperately needed include the high financial cost of childbirth, especially for uninsured people; the extent to which non-evidence-based practices continue to be the norm in many hospitals and physician practices; the growing number of women who report feeling traumatized by childbirth, even showing symptoms of post-traumatic stress disorder; and the general dissatisfaction registered by pregnant people who experience giving birth as disempowering and alienating.

These pregnant people sometimes choose to opt out of mainstream maternity care in order to protect their autonomy and make informed decisions about their care in future pregnancies. Against this sobering backdrop, this Article argues that midwifery represents a potential solution to the problems in the current maternity care system. Sometimes referred to as the oldest profession in the world, midwifery provides an

* Assistant Professor of Law, Drexel University Kline School of Law. LL.M., Temple University Beasley School of Law; J.D., New York University School of Law; MSc, London School of Economics; B.A. Yale University. Many thanks to the participants at the 2018 American Society of Law, Medicine, and Ethics (ASLME) Health Law Professors Conference (Cleveland, Ohio), 2019 Law & Society Association Annual Meeting (Washington, D.C.), and the 2019 SEALS Writing Connections Works in Progress Workshop for their feedback on this Article. I am particularly grateful to Tabatha Abu El-Haj, Meghan Boone, Caitlin Coslett, David Cohen, Rose Corrigan, Rob Field, Richard Frankel, Barry Furrow, Anil Kalhan, Amy Landers, Jill Wieber Lens, Maya Manian, Anne Mullins, Alexa Richardson, Christy Santoro, and especially Rachel Rebouché, for their helpful insights and suggestions. Thanks also to the editors of the *Temple Law Review* for their dedicated effort in preparing this Article for publication.

important alternative to the high-cost, high-intervention, high-complication model of birth that currently dominates the U.S. health care system.

This Article provides a critical analysis of restrictive regulations that exclude midwives or prevent them from practicing to the full extent of their training. It offers a brief history of the relationship between midwives and physicians since colonial days, showing how interprofessional cooperation and respect waned as physicians became increasingly professionalized and sought to advance obstetrics as an independent specialty with preeminent expertise in childbirth. These efforts established the conditions that have led to modern-day hostility towards midwives by the medical profession.

Because physicians oversee a majority of the relevant state licensing boards—and their professional organizations have strong political influence on state legislatures—doctors in many states have resisted competition from midwives by regulating them to the margins of maternity care. The Article highlights recent research showing that greater integration of midwives into mainstream maternity care is associated with better maternal and infant health outcomes and argues that current restrictive regulation is both unlawful and impedes progress on improving outcomes at a time when the United States is facing a maternal health crisis.

TABLE OF CONTENTS

INTRODUCTION	245
I. MATERNITY CARE IN THE UNITED STATES.....	254
A. <i>Where Birth Happens</i>	256
B. <i>Medical Model of Childbirth</i>	259
C. <i>Cost of Birth</i>	261
D. <i>Professional Strain on Obstetricians</i>	262
1. <i>Perverse Economic Incentives</i>	262
2. <i>Fear of Liability & Malpractice Rates</i>	265
3. <i>Declining Workforce</i>	267
E. <i>Obstetric Violence & Emotional Trauma</i>	268
II. MIDWIFERY AS A (PARTIAL) SOLUTION	270
A. <i>Midwives Model of Care</i>	271
B. <i>Midwifery's Health & Safety Record</i>	275
C. <i>Economics of Midwifery</i>	278
D. <i>Benefits of Promoting & Integrating Midwives</i>	280
III. BARRIERS TO INTEGRATION OF MIDWIFERY	281
A. <i>Historical Marginalization of Midwives</i>	281
B. <i>Modern Marginalization of Midwives</i>	283
1. <i>Legislative Hostility</i>	284
2. <i>Regulatory Hostility</i>	286
C. <i>Case Study: Pennsylvania</i>	288
IV. DISMANTLING BARRIERS: APPLYING ANTITRUST SCRUTINY TO MIDWIFERY REGULATION	292
V. STRATEGIC OPPORTUNITIES FOR MIDWIFERY ADVOCATES	297
CONCLUSION	300

INTRODUCTION

Recent journalistic reporting on maternal mortality has focused public attention on the maternity care crisis in the United States, shocking readers with improbably high statistics and compelling stories of tragedy striking American families.¹ A steady parade of headlines has elevated maternal mortality as a matter of public concern—many years after advocates began criticizing the poor health outcomes of American mothers and calling for maternity care reform.² The statistics are indeed troubling. The United States has the highest rate of maternal deaths in the developed world—with people of color facing disproportionately high rates of adverse outcomes.³ Researchers estimate that seven hundred to nine hundred women die from pregnancy- or childbirth-related causes

1. See, e.g., Julia Belluz, *We Finally Have a New US Maternal Mortality Estimate. It's Still Terrible.*, VOX (Jan. 30, 2020, 10:40 AM), <http://www.vox.com/2020/1/30/21113782/pregnancy-deaths-us-maternal-mortality-rate> [https://perma.cc/VQ7D-6XKD]; Jessie Hellmann, *Maternal Deaths Keep Rising in US, Raising Scrutiny*, HILL (Apr. 19, 2018, 6:00 AM), <http://thehill.com/policy/healthcare/383847-lawmakers-pressed-to-act-as-us-struggles-with-maternal-deaths> [https://perma.cc/Y9GG-XTGJ]; Cara Heuser & Chavi Eve Karkowsky, *Why Is U.S. Maternal Mortality So High?*, SLATE (May 23, 2017, 1:51 PM), http://www.slate.com/articles/health_and_science/medical_examiner/2017/05/medical_error_isn_t_to_blame_for_our_high_maternal_mortality_rate.html [https://perma.cc/G5R6-66AM]; Nina Martin & Renee Montagne, *Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why*, NPR (Dec. 7, 2017, 7:51 PM), <http://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why> [https://perma.cc/MG2V-PFTF]; Nina Martin, Emma Cillekens & Alessandra Freitas, *Lost Mothers*, PROPUBLICA (July 17, 2017), <http://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy> [https://perma.cc/ZW96-2L4U] (identifying 134 of the women who died from pregnancy-related causes in 2016 and profiling some of them); Nina Martin & Renee Montagne, *The Last Person You'd Expect To Die in Childbirth*, PROPUBLICA (May 12, 2017), <http://www.propublica.org/article/die-in-childbirth-maternal-death-rate-health-care-system> [https://perma.cc/T23R-8SMK] [hereinafter Martin & Montagne, *The Last Person*] (reporting on a joint ProPublica and NPR investigation into the lives of childbearing women who have died since 2011 and soliciting stories from the public about loved ones lost during childbirth); Nina Martin, *The New U.S. Maternal Mortality Rate Fails To Capture Many Deaths*, PROPUBLICA (Feb. 13, 2020, 12:40 PM), <http://www.propublica.org/article/the-new-us-maternal-mortality-rate-fails-to-capture-many-deaths> [https://perma.cc/2XJC-WD78] [hereinafter Martin, *The New U.S. Maternal Mortality Rate*]; Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES (Apr. 11, 2018), <http://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html> [https://perma.cc/3EG8-FRVT].

2. Some commentators have noted their frustration with the way that recent reporting on maternal mortality implies that it is a newly discovered problem, as well as frustration with a continued lack of action, even in the aftermath of increased publicity. See, e.g., Danielle Jackson, *A Frustrating Year of Reporting on Black Maternal Health*, LONGREADS (June 2018), <http://longreads.com/2018/06/13/a-frustrating-year-of-reporting-on-black-maternal-health/> [https://perma.cc/9ET7-AGAW].

3. Martin & Montagne, *The Last Person*, *supra* note 1. American women are three times more likely than Canadian women to die during the childbearing year and are six times more likely to die than Scandinavian women. *Id.* According to the Centers for Disease Control and Prevention (CDC), these deaths include those that occur during pregnancy through the first year after delivery or termination. *Id.* However, the most recent data published by the CDC include only those deaths that occurred up to forty-two days postpartum, which suggests that current statistics represent an undercount. See Martin, *The New U.S. Maternal Mortality Rate*, *supra* note 1 (noting that this more limited data still ranks the United States fifty-fifth among all countries for maternal mortality, ahead of Ukraine but worse than Russia).

each year, and approximately sixty-five thousand experience life-threatening complications.⁴

Of particular concern, maternal deaths increased in the United States from 2000 through 2014, unlike the trend in other wealthy countries—and many countries with fewer resources—where maternal mortality rates have fallen during that period.⁵ This degree of loss is not necessary, especially in a wealthy nation that spends nearly 20% of its gross domestic product on health care.⁶ In fact, research suggests that 60% of maternal deaths in the United States are preventable, and many occur when postpartum complications are left untreated.⁷ In addition, every year more than twenty-three thousand infants die before turning one.⁸ The Organization for Economic Cooperation and Development (OECD) reports that American-born babies are “less likely to reach their first birthday than babies born in other wealthy countries.”⁹

While data on maternal and infant mortality certainly deserve sustained attention and action, they only tell a small part of the story of the current maternity care crisis in the United States. In recent years, an increasing number of women¹⁰ have come forward

4. Martin & Montagne, *The Last Person*, *supra* note 1. For a discussion of the problems with maternal mortality data collection and the uneven quality of data collected from birth certificates, see Joyce A. Martin, Elizabeth C. Wilson, Michelle J.K. Osterman, Elizabeth W. Saadi, Shae R. Sutton & Brady E. Hamilton, *Assessing the Quality of Medical and Health Data from the 2003 Birth Certificate Revision: Results from Two States*, NAT'L VITAL STATS. REPS. (Nat'l Vital Stats. Sys., U.S. Dep't of Health & Human Servs., Hyattsville, Md.), July 22, 2013, at 1, 3 [hereinafter Martin et al., *Assessing the Quality*]. Data collection on maternal mortality and morbidity is so inconsistent, public health officials have not released an official tally of fatalities or an official maternal mortality rate since 2007. See Robin Fields, *Maternal Deaths Are Increasing in Texas, but Probably Not as Much as We Thought*, PROPUBLICA (Jan. 4, 2018, 11:30 AM), <http://www.propublica.org/article/maternal-deaths-are-increasing-in-texas-but-probably-not-as-much-as-we-thought> [https://perma.cc/J7N2-NBQG] (reporting on anomalies in the Texas health statistics that “epitomize the woeful record keeping on maternal deaths nationwide”); see also Ina May Gaskin, *Maternal Death in the United States: A Problem Solved or a Problem Ignored?*, 17 J. PERINATAL EDUC. 9, 10–11 (2008) (noting a study that documented a 93% underreporting rate of maternal death in Massachusetts to illustrate the widespread issue of maternal death underreporting).

5. See Martin & Montagne, *The Last Person*, *supra* note 1.

6. See *NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> [https://perma.cc/JQZ4-KVRB] (last updated Mar. 24, 2020).

7. BUILDING U.S. CAPACITY TO REVIEW AND PREVENT MATERNAL DEATHS, REPORT FROM NINE MATERNAL MORTALITY REVIEW COMMITTEES 6 (2018); see also *Pregnancy-Related Deaths*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/vitalsigns/maternal-deaths/index.html> [https://perma.cc/5JFH-7FJW] (last updated May 7, 2019).

8. Zoë Carpenter, *What's Killing America's Black Infants?*, NATION (Feb. 15, 2017), <https://www.thenation.com/article/whats-killing-americas-black-infants/>.

9. David Johnson, *American Babies Are Less Likely To Survive Their First Year than Babies in Other Rich Countries*, TIME (Jan. 9, 2018, 11:00 AM), <http://time.com/5090112/infant-mortality-rate-usa/> [https://perma.cc/ZD77-KFGX] [hereinafter Johnson, *American Babies*].

10. In certain places, this Article refers to people seeking care in pregnancy and childbirth as women, but it is important to recognize that some men and non-binary people also experience pregnancy and childbirth. See, e.g., Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7, 2014, 3:53 PM), <https://www.npr.org/sections/health-shots/2014/11/07/362269036/transgender-men-who-become-pregnant-face-health-challenges> [https://perma.cc/7Z6Q-UGVQ]. More research is needed on the experiences of transgender individuals seeking maternity care in mainstream health care institutions and the role of midwives in providing culturally appropriate care for transgender and gender nonconforming pregnant

to share stories of alienation, mistreatment, and even violence that they have experienced in health care settings while giving birth,¹¹ prompting some commentators to wonder whether childbirth is experiencing its own #MeToo moment.¹² Women have described the routinization of modern maternity care, which reflects industry-wide demands to make the delivery of health care services more efficient,¹³ and their experiences of not being listened to as patients, which can lead to adverse physical consequences and a dehumanizing birth experience.¹⁴ They recount the many ways their labors and deliveries were intervened upon, thereby transforming a natural physiological process into a medicalized experience through administration of drugs, IVs, computer monitors, and restrictions on movement and eating.¹⁵ While some pregnant people welcome a high level of clinical surveillance and medical management of labor, others report that the process of giving birth felt pathologized and fraught with danger—even though there were no actual medical complications¹⁶—and that they lacked agency to make informed treatment decisions as labor progressed.¹⁷

Other pregnant people recount birth experiences that reflect the various barriers that prevent certain patients from obtaining appropriate care. Some encounter unexpected

people. See Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 OBSTETRIC MED. 4, 6 (2016) (noting that transgender respondents sought midwifery care at a much higher rate (46%) than the U.S. national average (8.2%)). For accuracy, this Article will use the term “pregnant people” in general discussion and “women” when discussing particular examples, cases, or research involving only women, even though the research findings may be applicable to all pregnant people.

11. See E-mail from Dawn Thompson, Cristen Pascucci & Heather Thompson, Improvingbirth.org, to the World Health Organization (Sept. 25, 2014), <http://improvingbirth.org/2014/09/respectful-care/> [<https://perma.cc/EBT5-YYZ6>] (discussing a campaign by the consumer advocacy group Improving Birth called #BreakTheSilence, which prompted hundreds of responses “describing bullying, coercion, forced interventions, refusal to provide pain medication, and refusal to provide care in childbirth”).

12. See Kathi Valeii, *Birth Needs a #MeToo Reckoning*, DAME (June 18, 2018), <http://www.damemagazine.com/2018/06/18/birth-needs-a-metoo-reckoning/> [<https://perma.cc/S2NJ-68J6>].

13. See, e.g., EMILY MARTIN, *THE WOMAN IN THE BODY: A CULTURAL ANALYSIS OF REPRODUCTION* 140–44 (3d ed. 2001) (recounting experiences of birthing women in an anthropological study that analogizes labor management practices in obstetrics to labor management practices in industrial relations).

14. See Maya Salam, *For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.*, N.Y. TIMES (Jan. 11, 2018), <http://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html> [<https://perma.cc/TSJ6-A9CB>] (recounting when Serena Williams alerted a nurse to symptoms of a pulmonary embolism shortly after giving birth, and the nurse “suggested that pain medication had perhaps left Ms. Williams confused”).

15. See, e.g., EUGENE R. DECLERCQ, CAROL SAKALA, MAUREEN P. CORRY, SANDRA APPLEBAUM & ARIEL HERRLICH, *CHILDBIRTH CONNECTION, LISTENING TO MOTHERS III: PREGNANCY AND BIRTH*, at XI–XIII (2013) (summarizing data regarding the frequent use of various interventions during childbirth).

16. See, e.g., Helen Hazen, “*The First Intervention is Leaving Home*”: *Reasons for Electing an Out-of-Hospital Birth Among Minnesotan Mothers*, 31 MED. ANTHROPOLOGY Q. 555, 555 (2017) (reporting perceived pathologization of birth as a factor in women’s decisions to choose out-of-hospital birth); Samantha Vincenty, *I’m Nine Months Pregnant and I’m Terrified of Childbirth*, OPRAH MAG. (Dec. 12, 2008), <http://www.oprahmag.com/life/health/a25308433/tocophobia-fear-of-childbirth-essay/> [<https://perma.cc/VX4C-DF98>] (“[W]e’ve medicalized birth to the point where fear is a normative experience” (quoting University of Michigan Clinical Assistant Professor of Nursing, Lee Roosevelt)).

17. See, e.g., Cristen Pascucci, *Caught on Video: Improving Birth Breaks the Silence on Abuse of Women in Maternity Care*, IMPROVING BIRTH (Aug. 28, 2014), <http://improvingbirth.org/2014/08/vid/> [<https://perma.cc/J4KR-GG5D>] (publishing testimonials about women’s experiences with lack of informed consent during childbirth).

costs¹⁸ or long appointment wait times due to an insufficient number of obstetricians practicing in the area.¹⁹ Some pregnant people report wanting to hire a doula for emotional support during labor, but without insurance coverage, arranging this additional support is simply cost prohibitive.²⁰ Some cannot access the midwifery care they want because legal restrictions or other barriers to entry make it difficult for midwives to establish practices, or there is an insufficient number of practicing midwives in the area to meet client demand.²¹ Others are unable to find a health care provider willing to support their decision to pursue a vaginal birth after cesarean (VBAC), forcing them to travel further for care or submit to an unnecessary and unwanted repeat cesarean.²²

Some pregnant people of color experience bias and stereotyping as care providers respond skeptically to their reports of symptoms and question their commitment to following prenatal nutritional recommendations or refraining from illegal drug use, regardless of whether a patient has previously used drugs.²³ Pregnant people of color may make it through their entire pregnancy without encountering a single person of color on their clinical care team, increasing their sense of alienation or distrust of their care providers.²⁴ LGBTQ pregnant people report feeling vulnerable, prompted to explain their fertility journey each time they seek prenatal care and put in the position of having to correct providers' biased assumptions if on first glance their family structure does not appear to conform to a heteronormative model.²⁵

18. See Charlotte Cowles, *How Much Does it Actually Cost to Give Birth?*, CUT (Dec. 14, 2018), <http://www.thecut.com/2018/12/how-much-does-it-actually-cost-to-give-birth.html> [https://perma.cc/2MY3-DT6Z]; Olga Khazan, *The High Cost of Having a Baby in America*, ATLANTIC (Jan. 6, 2020), <http://www.theatlantic.com/health/archive/2020/01/how-much-does-it-cost-have-baby-us/604519/> [https://perma.cc/DV6S-VHYL].

19. Barbara Brody, *The Ob-Gyn Shortage Is Real—And It Might Impact Your Care*, GLAMOUR (Nov. 14, 2018), <http://www.glamour.com/story/ob-gyn-shortage> [https://perma.cc/N27Z-5V9Y].

20. See Carey Goldberg, *In Mass. and Beyond, State Lawmakers Push for Medicaid Coverage of Birth Doulas*, WBUR (Sept. 20, 2019), <http://www.wbur.org/commonhealth/2019/09/20/doula-medicare-massachusetts-birth> [https://perma.cc/CFY8-PPWP]; Katy Backes Kozhimannil & Rachel Hardeman, *How Medicaid Coverage for Doula Care Could Improve Birth Outcomes, Reduce Costs, and Improve Equity*, HEALTH AFF. BLOG (July 1, 2015), <http://www.healthaffairs.org/doi/10.1377/hblog20150701.049026/full/> [https://perma.cc/HTP6-SBCL].

21. See *infra* Parts III.B and III.C for a discussion of the legal barriers faced by modern midwives.

22. See Elizabeth Kukura, *Choice in Birth: Preserving Access to VBAC*, 114 PENN ST. L. REV. 955, 962–67 (2010) (discussing restrictions on access to VBAC in hospital-based settings) [hereinafter Kukura, *Choice in Birth*]; Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 743–47 (2018) [hereinafter Kukura, *Obstetric Violence*] (discussing the impact of VBAC restrictions on pregnant people).

23. See, e.g., Nina Martin & Renee Montagne, *Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017, 8:00 AM), <http://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth> [https://perma.cc/F48E-UC93] [hereinafter Martin & Montagne, *Nothing Protects Black Women*] (“Over and over, black women told of medical providers who equated being African American with being poor, uneducated, noncompliant and unworthy.”); Laurie Zephyrin, *Pregnancy-Related Deaths Reflect How Implicit Bias Harms Women. We Need to Fix That*, STAT (July 10, 2019), <https://www.statnews.com/2019/07/10/pregnancy-related-deaths-implicit-bias/> [https://perma.cc/VGN6-H2FE].

24. See Martin & Montagne, *Nothing Protects Black Women*, *supra* note 23 (“Limited diversity in the medical profession contributes to the black mothers’ sense of alienation.”).

25. Isabel Gregg, *The Health Care Experiences of Lesbian Women Becoming Mothers*, 22 NURSING FOR WOMEN’S HEALTH 40, 47–49 (2018) (discussing homophobia and heteronormativity in maternity care); see also

As the coronavirus (COVID-19) reached the United States and spread quickly in the early spring of 2020, it further burdened an already strained health care system with several pressures, including caring for both healthy pregnant people and those who tested positive for COVID-19, preventing further spread of COVID-19 among pregnant patients and their families, and protecting the physical and mental health of health care providers.²⁶

Existing problems—such as gaps in access to prenatal care and the limited availability of community birth options,²⁷ shortages in the perinatal health care workforce, and unnecessary medical intervention during childbirth—became more acute as COVID-19 continued to spread and hospitals tightened their policies about in-person appointments, the presence of support people during delivery, and postpartum care.²⁸ This burden has disproportionately fallen on poor women and women of color,²⁹ who were already at greater risk of suffering adverse health outcomes while giving birth.³⁰

MICHAEL J. MCDOWELL & IMAN K. BERRAHO, NAT'L LGBT HEALTH EDUC. CTR., LEARNING TO ADDRESS IMPLICIT BIAS TOWARDS LGBTQ PATIENTS: CASE SCENARIOS (Hilary Goldhammer, Jennifer Potter & Alex S. Keuroghlian eds., 2018) (identifying heteronormative assumptions by health care providers that may cause distress among patients).

26. See Sarah Benatar, Lisa Dubay & Ian Hill, *Improving Prenatal Care and Delivery in the Wake of COVID-19: Lessons From the Strong Start Evaluation*, HEALTH AFF. BLOG (June 23, 2020), <http://www.healthaffairs.org/doi/10.1377/hblog20200622.52532/full/> [<https://perma.cc/6UCJ-UBHE>] (“[T]he coronavirus pandemic is forcing us to closely examine the weaknesses of America’s traditional maternity care systems”); Wendy Ruderman, *Fearing Coronavirus at Hospitals, These Pregnant Women Would Rather Give Birth at Home, Despite Risks*, PHILA. INQUIRER (Apr. 18, 2020), <http://www.inquirer.com/health/coronavirus/pregnant-philadelphia-penn-insurance-home-birth-midwife-coronavirus-20200416.html> [<https://perma.cc/BZ2F-MSFX>] (identifying various challenges of childbirth during the pandemic from both provider and patient perspectives).

27. While childbirth in a freestanding birth center or at home has typically been referred to as “out-of-hospital birth,” health care providers attending such births have suggested that “community birth” is a more appropriate term, as it departs from the historical tendency to “reify hospital birth as normative” and “labels the practice for what it is—instead of for what it is not.” Melissa Cheyney, Marit L. Bovbjerg, Lawrence Leeman & Saraswathi Vedam, *Community Versus Out-of-Hospital Birth: What’s in a Name?*, 64 J. MIDWIFERY & WOMEN’S HEALTH 9, 9 (2019). This Article will use “community birth” and “out-of-hospital birth” interchangeably.

28. See Elizabeth Kukura, *Seeking Safety While Giving Birth During the Pandemic*, 14 ST. LOUIS U. J. HEALTH L. & POL’Y (forthcoming 2021) (manuscript at 1–4) (on file with author) [hereinafter Kukura, *Seeking Safety*] (arguing that the COVID-19 pandemic highlighted—and exacerbated—existing problems within the maternity care system, including limited access to midwife-attended community birth). For example, some hospitals instituted companion bans to limit the risk of COVID-19 exposure, which forced people to give birth without the doula support they wanted or, in some places, to birth alone without any support person. See *id.* at 11–14. Lack of support during labor and delivery is associated with longer labors, more cesareans, and less satisfying birth experiences. *Id.* at 12. In addition, non-evidence-based policies that separated newborns from their parents in the event of a suspected or confirmed COVID-19 result interfered with postpartum infant well-being, breastfeeding, bonding, and, importantly, the autonomy of birthing people. See *id.* at 16–20; see also Nofar Yakovi Gan-Or, *Going Solo: The Law and Ethics of Childbirth During the COVID-19 Pandemic*, J. L. & BIOSCIENCES, Jan.–June 2020, at 1, 3–11 (examining ethical issues raised by companion bans for childbearing people under COVID-19).

29. See generally Kukura, *Seeking Safety*, *supra* note 28.

30. See *infra* notes 49–59 and accompanying text for a discussion of the health risks that disproportionately affect these communities.

The emergence of COVID-19 also highlighted the need for midwives and access to out-of-hospital birth, as pregnant people experiencing low-risk pregnancies desperately sought community-based, midwife-attended births in order to avoid giving birth in hospital settings where the risk of virus transmission has been higher.³¹ Because unduly restrictive regulation—or the outright exclusion—of midwives from mainstream maternity care has stifled the growth of the profession, many people who have sought midwifery care in the midst of the pandemic were unable to find a provider or could not afford a community birth.³² Just as lack of emergency preparedness reveals weaknesses in infrastructure and resources once a crisis hits, the COVID-19 pandemic has brought to the fore longstanding problems with access to midwifery and coordination among maternity care service providers more generally.

This Article begins with the premise that the maternity care system in the United States is fundamentally flawed. Although the recent focus on maternal mortality has highlighted the problem of poor health outcomes for childbearing women and their babies, especially in communities of color, poor outcomes are only one of many indications that mainstream maternity care fails many pregnant people and their families.³³

Other signs that maternity care reform is desperately needed include the high financial cost of childbirth, especially for uninsured people;³⁴ the extent to which non-evidence-based practices continue to be the norm in many hospitals and physician practices;³⁵ the growing number of pregnant people who report feeling traumatized by childbirth, even showing symptoms of post-traumatic stress disorder;³⁶ and the general dissatisfaction registered by pregnant people who experience giving birth as disempowering and alienating, sometimes choosing to opt out of mainstream maternity

31. See Ruderman, *supra* note 26; Wendy Kline & Hermine Hayes-Klein, *Covid-19 Exposes the Need for Midwives*, WASH. POST (May 5, 2020, 6:00 AM), <http://www.washingtonpost.com/outlook/2020/05/05/midwives-tale/> [https://perma.cc/TD33-CQ7].

32. See Sophie Burkholder, *Covid-19 Sparked a Rising Interest in Home Births, but Not All Can Afford Them*, PHILA. INQUIRER (July 13, 2020), <http://www.inquirer.com/news/midwife-midwives-birth-covid-babies-delivery-20200712.html> [https://perma.cc/5FXZ-D37V].

33. This Article uses the term “mainstream maternity care” to refer to prenatal, delivery, and postpartum care delivered in a hospital setting by physicians and nurses—with the alternative including care delivered by hospital-based midwives and all births in freestanding birth centers or at home, whether assisted by midwives, physicians, or unassisted. Although some argue that hospital-based midwives’ faithfulness to the Midwives Model of Care is compromised by their institutional affiliation and supervision by physicians, hospital-based midwifery is not sufficiently common or widespread to be considered “mainstream.” See *infra* Part I.A for a discussion of the professional fragmentation that resulted in distinct forms of midwifery associated with site of practice.

34. See *infra* Part I.C for a discussion of the recent dramatic increases in the cost of birth.

35. See Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241, 265–85 (2016) [hereinafter Kukura, *Contested Care*] (describing evidence-based maternity care and the extent to which current clinical practices depart from the best available evidence).

36. See Antje Horsch & Susan Garthus-Niegel, *Posttraumatic Stress Disorder Following Childbirth*, in CHILD BIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL 49, 49–53 (Camilla Pickles & Jonathan Herring eds., 2020); Kukura, *Obstetric Violence*, *supra* note 22, at 754–56 (describing the harms obstetric violence can cause, including emotional trauma).

care in order to protect their autonomy and make informed decisions about their care in future pregnancies.³⁷

This Article argues that a potential solution to the problems in our current maternity care system is hiding in plain sight: midwives. Sometimes referred to as the oldest profession in the world, midwifery provides an important alternative to the high-cost, high-intervention, high-complication model of birth that currently dominates the U.S. health care system. The Midwives Model of Care prioritizes well-being throughout the childbearing cycle by providing individualized support during pregnancy and childbirth and by minimizing technological interventions.³⁸ Research shows that midwifery care promotes health and safety in birth and that the lower cost of midwifery care produces savings throughout the health care system, including for consumers and insurers.³⁹ Midwives are highly skilled experts in normal birth who should be integrated into the maternity care system, as is the case in many European nations that report adverse maternal and infant health outcomes at a fraction of the U.S. rates.⁴⁰

And yet, the United States has a fragmented and incoherent approach to regulating and integrating midwives into the health care system. This approach reflects a long history of competition and conflict between midwives and physicians, who have sought to marginalize midwives since the professionalization of medicine began in the nineteenth century.⁴¹ As part of that historical struggle, midwifery was fragmented into two subsets, consisting of nurse-midwives and direct-entry midwives. Nurse-midwives, who have formal nursing education, are recognized in all fifty states and the District of Columbia and are able to care for pregnant people in hospital or birth center settings, often under physician supervision.⁴²

In contrast, direct-entry midwives—sometimes called independent or non-nurse-midwives—generally operate outside hospitals, attending childbirth in birth centers or at

37. See, e.g., Jamie Santa Cruz, *Call the Midwife*, ATLANTIC (June 12, 2015), <http://www.theatlantic.com/health/archive/2015/06/midwives-are-making-a-comeback/395456/> [https://perma.cc/YZ9T-S3GJ] (noting that midwife-attended births have risen from 3% of all births in 1989 to almost 9% of all births in 2013 and attributing increased demand for midwifery care in part to the high rates of surgery and unnecessary intervention in hospital-based births).

38. See *The Midwives Model of Care*, MIDWIVES ALL. OF N. AM., <http://mana.org/about-midwives/midwifery-model> [https://perma.cc/JK2Z-ND2J] (last visited Feb. 1, 2021) (“The Midwives Model of Care includes: monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle[;] providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support[;] minimizing technological interventions[;] and identifying and referring women . . . who require obstetrical attention.”).

39. See *infra* Parts I.C, II.C.

40. See BIRTH MODELS THAT WORK 31–39 (Robbie Davis-Floyd et al. eds., 2009) (discussing the Dutch birth model and comparing it to other developed countries).

41. See Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN’S RTS. L. REP. 406, 414–21 (2014) (analyzing the negative implications of the professionalization of medicine for home birth midwifery); see also *infra* Part III.A.

42. Some nurse-midwives also offer home-birth services. Their ability to do so may depend on the extent of their clinical training in out-of-hospital birth and their access to a physician willing to enter into a collaborative agreement with a home-birth midwife. See *infra* Part III.B.2 for a discussion of collaborative agreement requirements as a form of unduly restrictive regulation.

home.⁴³ In recent decades, direct-entry midwives have become increasingly professionalized, but they face uncertain legal terrain in many jurisdictions and experience exclusion from mainstream health care institutions by other health care providers, hospitals, and insurers.⁴⁴ This exclusion limits access to midwives for low-risk pregnant people who are good candidates for midwifery care, especially women of color, rural women with few (or no) options for hospital-based care, and low-income women who cannot afford to pay out of pocket for a midwife-attended birth if they are uninsured or if Medicaid does not cover their midwifery care.

While midwives often experience interprofessional hostility on a personal level, their marginalization is enshrined in law and regulation at the state level. In most jurisdictions, regulatory barriers prevent midwives—both nurse-midwives and direct-entry midwives—from providing care to the full extent of their training and capabilities.⁴⁵ Such limitations inhibit the positive impact midwives can have on maternal and infant health and, in some circumstances, these limitations interfere with midwives' ability to provide appropriate care. They discourage the growth of midwifery as a profession and signal to the public that midwives are disfavored and should not be considered a reasonable, sensible, and health-affirming choice for pregnant people.

This Article identifies various state regulatory barriers that impede access to midwifery, thus limiting the ability of midwives to improve women's childbirth experiences and health outcomes. It then explores antitrust objections to the restriction of midwifery by physician-dominated regulatory boards, drawing on the Article's analysis of state regulation and recent research supporting the public health benefits of midwifery care to show how such regulatory barriers constitute impermissible economic exclusion. The Article concludes that antitrust principles require the dismantling of such impediments to full integration of midwifery in U.S. maternity care and suggests strategic opportunities to leverage legal and policy arguments in pursuit of regulatory reform.

Section I begins by describing modern maternity care in the United States, explaining how it became a hospital-based, physician-attended, and high-cost experience. In particular, childbirth-related care is characterized by high rates of intervention and a depersonalization that interferes with physician-patient trust and enables mistreatment by some health care providers who perceive themselves to be in conflict with their patients over medical decisionmaking. Section I also describes trends

43. See *About Us: Types of Midwives*, MIDWIVES ALL. OF N. AM., <http://mana.org/about-midwives/types-of-midwife> [<https://perma.cc/VL9Z-R8MS>] (last visited Feb. 1, 2021) [hereinafter MANA, *Types of Midwives*]. Certified Midwives, who represent a small proportion of direct-entry midwives, also attend births in hospitals. See *infra* notes 184–86 & accompanying text.

44. See, e.g., Lusero, *supra* note 41, at 427–29 (discussing insurance company exclusion of midwives); Elisabeth Rosenthal, *Getting Insurance To Pay for Midwives*, N.Y. TIMES (July 3, 2013, 12:51 PM), <http://well.blogs.nytimes.com/2013/07/03/getting-insurance-to-pay-for-midwives/> [<https://perma.cc/YH69-UTX8>] (discussing lack of insurance coverage for midwives); The Editors, *The U.S. Needs More Midwives for Better Maternity Care*, SCI. AM. (Feb. 1, 2019), <http://www.scientificamerican.com/article/the-u-s-needs-more-midwives-for-better-maternity-care/> [<https://perma.cc/RK3U-3VH6>] (noting the role obstetricians and state regulations have played in excluding midwives from hospitals).

45. See *State Ranking of Midwifery Integration Scores 2014–2015*, BIRTH PLACE LAB, <http://www.birthplacelab.org/how-does-your-state-rank/> [<https://perma.cc/5G8Y-JA4N>] (last visited Feb. 1, 2021) (providing individual scorecards detailing types of regulation that govern midwives in each state).

within the field of obstetrics that should introduce a new willingness to embrace and integrate midwives into mainstream maternity care, including the declining obstetrical workforce and the perception of a malpractice crisis for obstetricians.

Section II explores midwifery as a solution, at least in part, to systemic failures in the maternity care arena. Reform of health care financing to reduce financial incentives for unnecessary intervention continues to be an important priority, as do efforts to reduce the risk of malpractice liability for obstetricians.⁴⁶ The promotion and integration of midwives, however, represent a unique opportunity to improve maternal and infant health outcomes by increasing pregnant people's access to high-quality midwifery care and shifting the broader culture of birth within mainstream health care institutions. After comparing the Midwives Model of Care with the medical model employed in most hospital settings, Section II summarizes the research that demonstrates the health, safety, and cost benefits of midwife involvement in childbirth—all of which suggests that midwifery care should be available to anyone who wants it.

Section III examines existing legal and regulatory barriers to the integration of midwives, locating such restrictions in the historical marginalization of midwives by a professionalizing physician class. After surveying the types of hostility usually encountered by midwives in the legislative arena, including in the form of outright prohibitions on direct-entry midwifery practice, Section III focuses on various state regulations that impede the practice of midwifery across the nation. Perhaps most importantly, a state's decision to regulate midwives under its board of medicine, board of nursing, or elsewhere within the state agency structure determines the degree of restriction midwives encounter and, in some jurisdictions, may ultimately dictate whether midwifery can contribute positively to pregnant people's health outcomes and childbirth experiences. The fact that midwives in many states are subject to oversight by regulators with little to no relevant expertise—often including their direct economic competitors—interferes with the development of sensible, health-promoting rules and stifles the growth of a robust midwifery profession.

In order to illustrate the practical implications of state midwifery regulation, as well as the irrationality of current regulatory board structures in many states, Section III concludes with a case study of direct-entry midwifery in Pennsylvania. By focusing specifically on the conditions on the ground in Pennsylvania, this Section illustrates how such regulatory barriers interfere with a pregnant person's ability to access midwifery care.

Section IV then suggests leveraging antitrust principles against the regulatory barriers that midwives face. It argues that regulatory restrictions on midwifery practice constitute impermissible economic exclusion of midwives. Such regulation does not benefit consumers by protecting their health and safety or achieving some other pro-consumer goal. Rather, the regulations marginalize midwives, restricting their ability to practice to the full extent of their education and training out of a strategic desire to neutralize any competition they pose to other providers of maternity care services.

46. See Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 NEB. L. REV. 799, 840–46 (2016) [hereinafter Kukura, *Giving Birth Under the ACA*].

Under the Supreme Court's decision in *North Carolina Board of Dental Examiners v. FTC*,⁴⁷ state licensing boards that are predominantly composed of market participants must be actively supervised by the state in order to enjoy immunity from federal antitrust scrutiny.⁴⁸ This could expose physician-dominated regulatory boards to liability for their self-interested and anticompetitive regulation of midwives. As such, Section IV identifies strategic opportunities that the *Dental Examiners* decision and COVID-19 have provided for advocates to wrest control of midwifery regulation away from midwives' direct competitors and promote pro-maternal health regulatory board reform more broadly.

Finally, Section V draws on the foregoing analysis to outline potential strategic opportunities for midwifery advocates. This Section focuses on the need for regulatory board reform as an essential step in the growth and integration of midwifery into mainstream maternity care. Section V ends with a brief consideration of the possible impact of the COVID-19 pandemic on the pursuit of better birth through the expansion of midwifery.

I. MATERNITY CARE IN THE UNITED STATES

Although advocates have long been sounding the alarm about maternal health outcomes, especially for women of color, it is only recently that the general public and policymakers have begun to take notice.⁴⁹ This attention has brought to the fore the significant burden of the maternity care crisis borne by communities of color. Black women die from pregnancy-related causes at a disproportionately high rate and low-income women, rural women, and non-Black women of color also experience maternal mortality at higher rates than other women.⁵⁰ The CDC estimates that Black women are three to four times more likely than White women to die from childbirth-related causes.⁵¹ The Urban Health Institute reported a maternal mortality rate

47. 574 U.S. 494 (2015).

48. *Dental Exam'rs*, 574 U.S. at 511.

49. See, e.g., Gaskin, *supra* note 4, at 10–12 (discussing the problem of maternal mortality in historical context).

50. Jamila Taylor, Cristina Novoa, Katie Hamm & Shilpa Phadke, *Eliminating Racial Disparities in Maternal and Infant Mortality*, CTR. FOR AM. PROGRESS (May 2, 2019, 5:00 AM), <http://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/> [https://perma.cc/34E5-UVWQ]; see also Press Release, Ctrs. Disease Control & Prevention, Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths (Sept. 5, 2019).

51. See *Pregnancy Mortality Surveillance System*, CTRS. DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html> [https://perma.cc/NK46-NXSU] (last updated Feb. 4, 2020) (reporting, based on data submitted to the CDC for 2011–2016, a death rate of 42.4 per one hundred thousand live births for Black non-Hispanic women and 13.0 deaths per one hundred thousand live births for White non-Hispanic women); see also Myra J. Tucker, Cynthia J. Berg, William M. Callaghan & Jason Hsia, *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247, 247 (2007) (“For the past 5 decades, Black women have consistently experienced an almost 4-times greater risk of death from pregnancy complications than have White women.”).

for Native women that is 4.5 times greater than the maternal mortality rate for non-Hispanic White women.⁵²

Infants in the United States also die at higher rates than infants in other developed nations—with 5.7 deaths per one thousand live births in 2018—and even higher rates when they belong to racial and ethnic minority groups.⁵³ In 2018, the mortality rates out of one thousand births were 10.8 for non-Hispanic Black infants and 8.2 for Native American and Alaska Natives; by contrast, for non-Hispanic White children, the mortality rate was 4.6 out of one thousand births.⁵⁴

Research suggests that racism—not merely race or class—contributes to the stark disparities in childbirth outcomes. For example, a 2016 study revealed that Black, college-educated women who gave birth in New York City hospitals were more likely to experience severe complications than White women who did not complete high school.⁵⁵ Attempts to explain the disparities by suggesting that women of color have worse health status before becoming pregnant also fail. In a study that examined five medical complications that are significant causes of maternal mortality and morbidity, researchers found that Black women were two to three times more likely to die than White women who suffered the same condition.⁵⁶ Black women did not have higher prevalence rates of those five conditions than White women; Black women were simply more likely to die from them.⁵⁷ When public health researcher Arline Geronimus first proposed the “weathering hypothesis” in the early 1990s, she had observed that the Black-White infant mortality differential was greater at older maternal ages and suggested that Black women’s overall health may deteriorate at a faster pace as a “physical consequence of cumulative socioeconomic disadvantage.”⁵⁸ In the decades since, subsequent research has bolstered the conclusion that the corrosive effects of systemic racism in the United

52. Mary Annette Pember, *Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support*, REWIRE NEWS GROUP (July 9, 2018, 11:05 AM), <http://rewire.news/article/2018/07/09/amid-staggering-maternal-infant-mortality-rates-native-communities-revive-traditional-concepts-support/> [https://perma.cc/SPH8-U3WF]. The cofounder of a Native American center for Minnesota-based pregnant and birthing people, Millicent Simenson, expressed dismay at this reality, stating, “We stopped keeping statistics on the number of Native moms and babies that are lost in our region; it was just too upsetting.” *Id.*

53. *Infant Mortality*, CTRS. DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> [https://perma.cc/7A35-EWT9] (last updated Sept. 10, 2020). When compared with nineteen peer OECD nations, babies in the United States were three times more likely to die from prematurity. Johnson, *American Babies*, *supra* note 9 (noting that approximately three hundred thousand fewer American babies would have died if the United States had experienced the same overall decline in infant mortality that other OECD countries report since 1960).

54. *Infant Mortality*, *supra* note 53.

55. N.Y.C. DEP’T OF HEALTH & MENTAL HYGIENE, BUREAU OF MATERNAL, INFANT & REPRODUCTIVE HEALTH, NEW YORK CITY, 2008–2012: SEVERE MATERNAL MORBIDITY 15 (2016).

56. Tucker et al., *supra* note 51, at 248.

57. *Id.*

58. Arline T. Geronimus, *The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations*, 2 ETHNICITY & DISEASE 207, 207 (1992). For more discussion of weathering theory, see Gene Demby, *Making the Case that Discrimination Is Bad for Your Health*, NPR: CODE SWITCH (Jan. 14, 2018, 7:00 AM), <http://www.npr.org/sections/codeswitch/2018/01/14/577664626/making-the-case-that-discrimination-is-bad-for-your-health> [https://perma.cc/TQ2D-QDCY].

States place Black pregnant people and their babies at greater risk of adverse health outcomes.⁵⁹

The disproportionate impact of maternal and infant mortality on communities of color helps to explain why the United States reports worse outcomes than other high-resource countries. Any legal and policy interventions that prioritize the needs of pregnant people of color and their families will benefit all birthing people in the United States; likewise, efforts that minimize or ignore race and racism will likely fail to improve access to care, the quality of care, and health outcomes in a meaningful way.⁶⁰ Before exploring possible solutions, it is necessary to understand the landscape of maternity care provision in the United States, which—like the American health care system more generally—is complicated, fragmented, and, at times, contested. The remainder of this Section will describe trends in where and how birth happens,⁶¹ the financial cost of childbirth in the United States,⁶² critical issues facing obstetrics as a profession,⁶³ and the role of coercion and other provider mistreatment in shaping pregnant people's experiences and health outcomes.⁶⁴

A. *Where Birth Happens*

Until the late nineteenth century, it was normal for women to deliver their babies at home, assisted by a midwife and in the company of female relatives and friends who gathered to offer support.⁶⁵ As physicians became increasingly professionalized, some doctors saw childbirth as an opportunity to increase demand for their services and began marketing themselves as providers of a more modern and supposedly healthier “scientific” childbirth, which included the increased use of instruments, such as forceps, to aid with delivery.⁶⁶ The rise of physician-attended childbirth drew more women with

59. See, e.g., Jeanne L. Alhusen, Kelly Bower, Elizabeth Epstein & Phyllis Sharps, *Racial Discrimination and Adverse Birth Outcomes: An Integrative Review*, 61 J. MIDWIFERY & WOMEN'S HEALTH 707, 707 (2016) (finding racial discrimination is a significant risk factor for adverse birth outcomes); Tyan Parker Dominguez, Christine Dunkel-Schetter, Laura M. Glynn, Calvin Hobel & Curt A. Sandman, *Racial Differences in Birth Outcomes: The Role of General, Pregnancy, and Racism Stress*, 27 HEALTH PSYCHOL. 194, 194 (2008) (finding perceived racism was a significant predictor of birth weight in African Americans but not in non-Hispanic Whites); Rihitu Chatterjee & Rebecca Davis, *How Racism May Cause Black Mothers To Suffer the Death of Their Infants*, NPR (Dec. 20, 2017, 5:01 AM), <http://www.npr.org/sections/health-shots/2017/12/20/570777510/how-racism-may-cause-black-mothers-to-suffer-the-death-of-their-infants> [<https://perma.cc/V8WB-DHGN>].

60. See 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, 45–46 (2016) (calling for intersectional analysis that grapples with both race and gender in order to advance midwifery).

61. See *infra* Parts I.A, I.B.

62. See *infra* Part I.C.

63. See *infra* Part I.D.

64. See *infra* Part I.E.

65. See Catherine M. Scholten, “On the Importance of the Obstetrick Art”: Changing Customs of Childbirth in America, 1760 to 1825, 34 WM. & MARY Q. 426, 427 (1977) (“[C]hildbirth was an event shared by the female community; and delivery was supervised by a midwife.”).

66. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 49–50 (1982).

resources to the hospital to deliver, especially after the introduction of medication to relieve the pain of labor.⁶⁷

Although the increase in hospital-based, physician-attended birth did not coincide with improved health outcomes, these changes initiated a trend that led to the marginalization of midwives as the primary providers of childbirth-related assistance.⁶⁸ By the dawn of the twentieth century, physicians attended approximately half of all births.⁶⁹ By mid-century, the displacement of midwives had been effective, though it reflected ongoing racial stratification: in 1935, 5% of White women and 54% of Black women used midwives, and by 1953, only 3% of White women and 20% of Black women continued to seek out midwifery services.⁷⁰

Even as increasing numbers of women chose to deliver their babies in hospitals with physicians, poor women in rural areas suffered a lack of access to maternity care.⁷¹ This public health concern led to the creation of the Frontier Nursing Service (FNS) in Kentucky in 1925 and the first training program for nurse-midwives in 1932.⁷² The creation of nurse-midwifery represented an essential, life-saving service and preserved midwifery knowledge in certain areas of the country to the benefit of future generations, but this development also led to the further splintering of midwifery as a field and laid the groundwork for various restrictions on midwifery practice that persist today.⁷³ In addition, FNS founder Mary Breckinridge's refusal to employ Black nurse-midwives contributed to race-based divisions within midwifery, further fracturing the profession and creating midwifery-oriented spaces that were marked by exclusionary policies and attitudes.⁷⁴

Direct-entry midwifery saw the beginning of a revival in the women's health movement of the 1970s with the movement's critique of mainstream medicine's

67. JUDITH WALZER LEAVITT, *BROUGHT TO BED: CHILDBEARING IN AMERICA 1750 TO 1950*, at 40 (1986) ("The prospect of a difficult birth . . . led women to seek out practitioners whose obstetric armamentarium included drugs."); Suzanne Hope Suarez, *Midwifery Is Not the Practice of Medicine*, 5 *YALE J.L. & FEMINISM* 315, 329 (1993).

68. See Judith P. Rooks, *Nurse-Midwifery: The Window Is Wide Open*, 90 *AM. J. NURSING* 30, 31 (1990) (discussing a 1925 conference at the White House where it was announced that "the record of trained midwives . . . surpasses the record of physicians in normal deliveries"); see also Paula A. Michaels, *Childbirth and Trauma, 1940s–1980s*, 73 *J. HIST. MED. & ALLIED SCI.* 52, 55 (2017) (discussing twentieth century advances in antiseptic practices and how the introduction of antibiotics that reduced mortality rates did not begin until the 1940s).

69. LEAVITT, *supra* note 67, at 161–62.

70. George W. Lewis & Peter G. McCaffery, *Sociological Factors Affecting the Medicalization of Midwifery*, in *MIDWIFERY AND THE MEDICALIZATION OF CHILDBIRTH: COMPARATIVE PERSPECTIVES* 5, 24 (Edwin Van Teijlingen et al. eds., 2004).

71. See Nancy Schrom Dye, *Mary Breckinridge, the Frontier Nursing Service and the Introduction of Nurse-Midwifery in the United States*, 57 *BULL. HIST. MED.* 485, 488 (1983).

72. *Id.* at 485, 506; see also Katy Dawley, *Origins of Nurse-Midwifery in the United States and Its Expansion in the 1940s*, 48 *J. MIDWIFERY & WOMEN'S HEALTH* 86, 88 (2003) (recalling Mary Breckinridge's creation of the FNS).

73. See *infra* Section III for a discussion of modern barriers to midwifery.

74. See Dana Allen Johnson, "A Cage of Ovulating Females": Mary Breckinridge and the Politics of Contraception in Rural Appalachia 43 (July 2010) (unpublished M.A. thesis, Marshall University), <http://pdfs.semanticscholar.org/9ecb/930d37fbef9339a2b0f090805b872a575fab.pdf> [<https://perma.cc/HF8C-YYK5>].

treatment of women and feminist activists' pursuit of self-help in gynecologic care.⁷⁵ A renewed interest in natural birth inspired the establishment of birth centers in local communities around the country and the founding of The Farm, an intentional community in Tennessee with a reputation for positive birth outcomes and experiences under the leadership of self-taught midwife Ina May Gaskin.⁷⁶ The largely White alternative birth movement that raised the profile of direct-entry midwifery in the second half of the twentieth century worked with sympathetic physicians to learn midwifery skills and manage complications, but it largely ignored the history and vast practical knowledge base of African American "granny" midwives, some of whom were still alive and practicing under the radar in southern states.⁷⁷

Although 98% of births still take place in the hospital, community birth in freestanding birth centers or at home continues to provide options for pregnant people seeking midwifery care or out-of-hospital birth experiences, offering a low-intervention and lower-cost alternative to hospital birth.⁷⁸ There are approximately 384 freestanding birth centers currently in operation across the United States.⁷⁹ A provision of the 2010 Patient Protection and Affordable Care Act⁸⁰ required that states provide Medicaid reimbursement for birth center facility service fees and the professional fees of birth center attendants, which increased access to midwifery care for low-income people located near a freestanding birth center.⁸¹

Indeed, although community births represent a small percentage of the overall number of births recorded annually in the United States, the numbers have been increasing: jumping 85% from 0.87% of births in 2004 to 1.61% of births in 2017.⁸² Of those, approximately one in three took place in a freestanding birth center and two-thirds

75. See Judith P. Rooks, *The History of Midwifery*, OUR BODIES, OURSELVES (May 30, 2012), <http://www.ourbodiesourselves.org/book-excerpts/health-article/history-of-midwifery/> [<https://perma.cc/8Q4W-D4FZ>].

76. Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 LAW & SOC'Y REV. 125, 131–32, 136–37 (2005). See generally INA MAY GASKIN, SPIRITUAL MIDWIFERY (4th ed. 2002) (explaining Gaskin's approach to childbirth and midwifery).

77. See, e.g., Nine Renata Aron, *Meet the Unheralded Women Who Saved Mothers' Lives and Delivered Babies Before Modern Medicine*, MEDIUM (Jan. 12, 2018), <http://timeline.com/granny-midwives-birther-rural-babies-and-saved-lives-33f12601ba84> [<https://perma.cc/ND65-4ZXG>].

78. Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 280 (2019) (explaining that 1.61% of births in the United States in 2017 were out-of-hospital births, including births at home and in birth centers).

79. History, AM. ASS'N BIRTH CTRS., <http://www.birthcenters.org/page/history#:~:text=2020%20%2D%20Birth%20centers%20continue%20to,in%2037%20states%20and%20DC> [<https://perma.cc/AU4J-SEHV>] (last visited Feb. 1, 2021) ("There are now more than 384 freestanding birth centers in the United States in 37 states and DC."). The growth of freestanding birth centers has led some hospitals to establish hospital-based birth centers that are staffed by midwives and cater to consumers seeking a less-interventionist approach to childbirth, in an attempt to prevent loss of market share among healthy, low-risk pregnant people.

80. Pub. L. No. 111-148, § 2301, 124 Stat. 119, 292 (2010) (codified at 42 U.S.C. § 1396d(l)(3)(C) (2018)).

81. See 42 U.S.C. § 1396d(l)(3)(B)–(C) (defining "freestanding birth centers" as health facilities where women give birth that are not hospitals or patient residences).

82. MacDorman & Declercq, *supra* note 78, at 280.

were home births.⁸³ In the face of increased consumer interest in options for community birth, major medical societies have taken strong positions in opposition to home birth and have actively opposed legislative efforts to license midwives or liberalize access to midwifery.⁸⁴ The political fights about home birth over the last several decades have often obscured the role and value of midwives and confused the public about the health and safety benefits of midwifery care.⁸⁵

B. Medical Model of Childbirth

Culturally and clinically, the United States has embraced a medical model that conceptualizes birth as a condition to be managed or disease to be cured, rather than a normal physiologic process. The medicalization of birth is reflected in obstetrics textbooks and hospital protocols.⁸⁶ Following a medical model results in high rates of intervention, reflecting an assumption that more intervention in the birth process is desirable because it increases safety without additional risk.⁸⁷ However, this interventionist bias tends to devalue certain risks, such as the increased risk of complications in future pregnancies, and persists despite evidence that various common interventions have not made birth safer.⁸⁸

Of the more than 98% of people who give birth in a hospital,⁸⁹ very few experience childbirth without some type of intervention. Childbirth interventions take many forms. Familiar to many, cesarean surgery is the mode of delivery for approximately one in three babies each year in the United States.⁹⁰ This exceeds the World Health Organization's recommendation that 10–15% of births in high-resource countries be

83. See *id.* (stating that out of 62,228 out-of-hospital births in 2017, 38,343 births were home births, and the remaining 19,878 births occurred in birth centers).

84. See, e.g., Am. Coll. of Obstetricians & Gynecologists, *Home Deliveries*, AMA Res. 205 (A-08) (Apr. 28, 2008) (approved by the American Medical Association House of Delegates), http://www.ftc.gov/system/files/documents/public_comments/2014/03/00041-88892.pdf [<https://perma.cc/5XHX-SLAU>]; see *infra* Section IV.

85. See, e.g., Sandi Doughton, *Trying To Clear Up the Confusion About Midwives. Who Are They and What Do They Do?*, SEATTLE TIMES: PAC. NW MAG. (Mar. 15, 2020, 7:00 AM), <http://www.seattletimes.com/pacific-nw-magazine/trying-to-clear-up-the-confusion-about-midwives-in-washington-who-are-they-and-what-do-they-do/> [<https://perma.cc/7WJL-BNZ7>] (noting public confusion about midwifery due to different professional tracks, educational requirements, and practice settings).

86. See, e.g., WILLIAMS OBSTETRICS (F. Gary Cunningham et al. eds., McGraw Hill Educ. 25th ed. 2018).

87. See Alice Dreger, *The Most Scientific Birth Is Often the Least Technological Birth*, ATLANTIC (Mar. 20, 2012), <http://www.theatlantic.com/health/archive/2012/03/the-most-scientific-birth-is-often-the-least-technological-birth/254420/> [<https://perma.cc/73VD-GM8X>] (discussing the misconception that more technological intervention makes birth safer).

88. See Kukura, *Contested Care*, *supra* note 35, at 267–77.

89. MacDorman & Declercq, *supra* note 78, at 279 (reporting that in 2017 only 1.61% of births occurred outside of a hospital).

90. See Joyce A. Martin, Brady E. Hamilton, Michelle J.K. Osterman, Anne K. Driscoll & Patrick Drake, *Births: Final Data for 2016*, NAT'L VITAL STATS. REPS. (Nat'l Vital Stats. Sys., U.S. Dep't Health & Human Servs., Hyattsville, Md.), Jan. 31, 2018, at 7 (reporting that 31.9% of babies born in the United States in 2016 were by cesarean). The cesarean rate peaked in 2009 at 32.9%, having increased every year since 1996 when it was 20.7%. *Id.*

cesarean deliveries.⁹¹ Other common interventions during labor and delivery occur with a high frequency and under circumstances not indicated by the best available research,⁹² suggesting that American women—the vast majority of whom experience low-risk pregnancies⁹³—experience unnecessary administration of medication, unnecessary invasive monitoring, and unnecessary surgery while giving birth. For example, a recent survey of women’s childbearing experiences revealed that 62% of women reported being hooked to an IV during labor, 47% had bladder catheters, 31% were given synthetic oxytocin to expedite labor, and 20% reported that their membranes had been broken to release amniotic fluid after labor had begun (in the hopes of speeding up the delivery).⁹⁴ Overall, either to induce or augment labor, 50% of women received synthetic oxytocin and 36% had their membranes broken.⁹⁵ It is also clear that certain interventions raise the likelihood of needing subsequent interventions to manage complications or treat side effects of the original procedure in what researchers refer to as a “cascade of secondary interventions.”⁹⁶

Some interventions persist despite a lack of demonstrated benefit. For example, continuous electronic fetal monitoring (EFM) is almost universal in hospital-based maternity care, despite the fact that research shows continuous fetal monitoring has not improved fetal outcomes but does result in a high number of false positives leading to unnecessary surgeries.⁹⁷ Although research shows that mobility during labor shortens its

91. World Health Organisation, *Appropriate Technology for Birth*, 326 LANCET 436, 437 (1985) (“There is no justification for any region to have a rate higher than 10–15%.”); Press Release, World Health Org. Caesarean Sections Should Only Be Performed When Medically Necessary, (Apr. 10, 2015), <http://www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/> [https://perma.cc/R84E-SGEV]; see also Fernando Althabe & José M. Belizán, *Cesarean Section: The Paradox*, 368 LANCET 1472, 1472–73 (2006) (“For the health of both the mother and the neonate . . . a frequency of [caesarean sections] between 5% and 10% seems to achieve the best outcomes, whereas a rate of less than 1%, or of higher than 15% seems to result in more harm than good.”). More recent research suggests that a 19% cesarean rate is the benchmark for the United States. Martha Bebinger, *Study Suggests 19 Percent Could Be Benchmark C-Section Rate*, WBUR (Dec. 1, 2015), <http://www.wbur.org/commonhealth/2015/12/01/benchmark-caesarean-section-rate> [https://perma.cc/32YT-AKYJ].

92. See Kukura, *Contested Care*, *supra* note 35, at 244.

93. See *High-Risk Pregnancy*, UNIV. CAL. S.F. HEALTH, <http://www.ucsfhealth.org/conditions/high-risk-pregnancy> [https://perma.cc/NEH3-SH7A] (last visited Feb. 1, 2021) (“High-risk complications occur in only 6 percent to 8 percent of all pregnancies.”).

94. DECLERCQ ET AL., *supra* note 15, at 18.

95. *Id.*

96. CAROL SAKALA & MAUREEN P. CORRY, CHILDBIRTH CONNECTION, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 28 (2008). LISTENING TO MOTHERS III reported that, of people experiencing their first pregnancy and labor, 47% experienced an induction, and, of those having an induction, 78% had an epidural. DECLERCQ ET AL., *supra* note 15, at 24. Among people who had both an induction and an epidural, 31% ultimately had a cesarean. *Id.* Those who experienced induction or an epidural—but not both—had cesarean rates of 19–20%. *Id.*

97. See Zarko Alfirevic, Gillian M.L. Gyte, Anna Cuthbert & Declan Devane, *Continuous Cardiotocography (CTG) as a Form of Electronic Fetal Monitoring (EFM) for Fetal Assessment During Labour*, COCHRANE DATABASE SYSTEMATIC REV., 2019, at 1, 1–2; Thomas P. Sartwelle, James C. Johnston & Berna Arda, *A Half Century of Electronic Fetal Monitoring and Bioethics: Silence Speaks Louder Than Words*, 3 MATERNAL HEALTH, NEONATOLOGY & PERINATOLOGY, Nov. 21, 2017, at 1, 4.

duration and discomfort⁹⁸—enabling gravity to assist in the baby’s descent and allowing the pregnant person to adjust to find more comfortable positions during labor—hospitals continue to confine laboring people to beds in order to enable remote monitoring of fetal heart rates at the nurses’ station and to generate a record in the event of subsequent litigation.⁹⁹

A full account of the medicalization of childbirth is beyond the scope of this Article, but it is nevertheless clear that a medicalized orientation toward birth took hold as physicians increasingly replaced midwives as primary birth attendants. Historians have captured the cultural shift in descriptions of a Boston physician who, in the 1920s, opined that women should think of birth “not as ‘something natural and normal, and not worth the time of obstetricians and specialists’ charges,” but as ‘a complicated and delicately adjusted process, subject to variations from the normal which may be disastrous to the mother or baby, or both.’”¹⁰⁰ As physicians assumed authority over childbirth, they were “on the lookout for trouble in birth.”¹⁰¹ This mindset persists today in much hospital-based maternity care, leading to reliance on technological intervention out of a desire to secure predictable labor trajectories and control risk.¹⁰²

C. *Cost of Birth*

As in other areas of health care, the economics of maternity care are central to understanding the barriers to accessing care, the organization and reimbursement of childbirth services, and the pressures on physicians and hospitals that can shape clinical decisionmaking. In a recent survey on health care spending, the United States spent the most per capita on health care out of all developed countries¹⁰³—a fact that stands in stark contrast to the country’s poor rankings among peer nations on maternal and infant health outcomes.¹⁰⁴ The cost of birth has increased dramatically over the last two decades.¹⁰⁵ Hospital charges for childbirth now exceed expenditures for any other condition, totaling over \$111 billion in 2010.¹⁰⁶

98. Annemarie Lawrence, Lucy Lewis, G. Justus Hofmeyr & Cathy Styles, *Maternal Positions and Mobility During First Stage Labour (Review)*, COCHRANE DATABASE SYSTEMATIC REVIEWS, 2013, at 1, 2.

99. See Sartwelle et al., *supra* note 97, at 5–6.

100. RICHARD W. WERTZ & DOROTHY C. WERTZ, *LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA* 141 (Yale Univ. Press expanded ed. 1989) (1977) (quoting Judson Smith, *The Birth of a Baby*, BOS. EVENING TRANSCRIPT, Nov. 14, 1923, at 12).

101. *Id.* at 136.

102. See HENCI GOER & AMY ROMANO, *OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH* 16–17 (2012) (discussing the “ubiquity of the medical management model” and the way it acts as a “cultural blinder”).

103. Susan Brink, *What Country Spends the Most (and Least) on Health Care Per Person?*, NPR: GOATS AND SODA (Apr. 20, 2017, 11:26 AM), <http://www.npr.org/sections/goatsandsoda/2017/04/20/524774195/what-country-spends-the-most-and-least-on-health-care-per-person> [<https://perma.cc/6NG5-XNDD>].

104. See Johnson, *American Babies*, *supra* note 9.

105. Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), <http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html> [<https://perma.cc/F94S-J98E>] (noting that delivery charges have tripled since 1996).

106. See *United States Maternity Care Facts and Figures*, CHILDBIRTH CONNECTION: TRANSFORMING MATERNITY CARE, http://transform.childbirthconnection.org/wp-content/uploads/2012/12/maternity_care_in_US_health_care_system.pdf, [<http://perma.cc/BTK2-UGZT>] (last updated Dec. 2012).

The cost of birth may vary dramatically depending on whether someone delivers vaginally or by cesarean surgery. In 2010, the average charge for vaginal delivery (for someone covered by employer-sponsored insurance) was \$32,093, while the average charge for a cesarean was \$51,125.¹⁰⁷ In 2018, 43% of births were covered by Medicaid,¹⁰⁸ which pays lower average charges for both vaginal and cesarean deliveries.¹⁰⁹ Although wide variation in midwifery practice structure and availability of insurance reimbursement makes it difficult to generate an average charge for midwifery services, care by a midwife universally costs less than physician services—whether provided in a hospital, birth center, or home setting.¹¹⁰ Furthermore, midwifery care presents additional savings through avoided medical interventions that are costly and often require further costly interventions.¹¹¹

D. Professional Strain on Obstetricians

Although obstetricians get to experience the joy of helping families welcome their new babies into the world, they also face certain systemic pressures that increase the stress and strain of an already demanding profession. Because such pressures may impact clinical care and patient experiences, they are an important part of understanding the flaws in the U.S. maternity care system.

Part I.D.1 examines how the economic pressures obstetricians face may create perverse incentives that negatively impact clinical practice—even if the physician is not consciously aware of this influence. Part I.D.2 tackles the role of malpractice exposure in obstetrics and the risk that fear of liability may shape how physicians care for patients through the practice of defensive medicine. Finally, Part I.D.3 summarizes concerns about the shortage of obstetricians to meet demand for childbirth services, linking gaps in the obstetrics workforce to the need for an expanded role for midwives.

1. Perverse Economic Incentives

In some clinical settings, high rates of interventions—and the insistence on performing them—reflect economic pressures on individual physicians and hospital administrators to manage patient flow, as well as the unconscious (or conscious) influence of the incentives fee-for-service models create by rewarding more medical intervention during childbirth with higher fees.¹¹² Obstetrics is not a lucrative practice for hospitals, as illustrated by the number of facilities that have closed labor and delivery wards in recent decades.¹¹³ The desire to manage patient flow and maximize the number

107. TRUVEN HEALTH ANALYTICS, THE COST OF HAVING A BABY IN THE UNITED STATES 6 (2013).

108. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID'S ROLE IN FINANCING MATERNITY CARE 1 (2020).

109. TRUVEN HEALTH ANALYTICS, *supra* note 107, at 6.

110. Patricia A. Janssen, Craig Mitton & Jaafar Aghajanian, *Costs of Planned Home vs. Hospital Birth in British Columbia Attended by Registered Midwives and Physicians*, PLOS ONE, July 17, 2015, at 1 (concluding that the cost of midwifery care is lower than planned hospital birth with a physician).

111. See *infra* Part II.C for a discussion of the economics of midwifery.

112. See Kukura, *Giving Birth Under the ACA*, *supra* note 46, at 840–46; Kukura, *Obstetric Violence*, *supra* note 22, at 766–69 (discussing the role of economic pressure in obstetric violence situations).

113. See, e.g., MATERNITY CARE COALITION, HOSPITAL OBSTETRICAL CAPACITY IN SOUTHEASTERN PENNSYLVANIA 1 (2016), <http://maternitycarecoalition.org/wp-content/uploads/2016/04/Hospital-OB-Capacity->

of deliveries at a given facility creates perverse incentives to reduce labor duration, increase reimbursement per delivery, and predict demand on services.¹¹⁴

The desire of hospital administrators to increase capacity by moving patients through the delivery ward more quickly may help explain high rates of labor induction and augmentation through medication and other means. In fact, over time, the calculation of a “normal” duration of labor has shortened—from an average second stage of labor lasting eighty minutes in the 1971 edition of *Williams Obstetrics* to an average length of fifty minutes by the 1985 edition of the book—reflecting how the use of increased intervention has enabled physicians to control and hasten labor.¹¹⁵ The structure of maternity care financing also creates economic incentives that may influence clinical decisionmaking. Insurance companies reimburse for prenatal care and delivery using a global payment, meaning that providers may have an incentive to be present for the actual delivery in order to get paid for care previously provided.¹¹⁶ Some physicians may rely on artificial induction or augmentation of labor to time deliveries in order to maximize reimbursement. Procedures that fall outside the global charge for childbirth may accrue additional reimbursement for the provider or hospital, and thus may incentivize unnecessary intervention during labor and delivery, regardless of whether the desire for increased reimbursement has a conscious or subconscious influence on clinical decisionmaking.¹¹⁷

Report-FINAL.pdf [https://perma.cc/79AQ-37DQ] (finding that, from 1997 to 2009, the number of birthing hospitals in Philadelphia declined from nineteen to six).

114. See Kukura, *Giving Birth Under the ACA*, *supra* note 46, at 840–41 (discussing the effect of reimbursement models in creating various incentives for providers and hospitals that are “poorly aligned” with improving birth outcomes).

115. Compare LOUIS M. HELLMAN & JACK A. PRITCHARD WITH RALPH M. WYNN, *WILLIAMS OBSTETRICS* 396 (Prentice-Hall, Inc. 14th ed. 1971), with JACK A. PRITCHARD, PAUL C. MACDONALD & NORMAN F. GANT, *WILLIAMS OBSTETRICS* 337 (Prentice-Hall, Inc. 17th ed. 1985). Rushing the physiological changes that enable safe delivery increases the risks of complications for the birthing person and the baby. Recently, the American College of Obstetricians and Gynecologists (ACOG) addressed the trend toward shorter labor duration with a statement announcing that active labor actually takes longer than previously estimated, and women should be given more time to labor before being diagnosed with failure to progress. The fact that guidelines regarding the stages of labor continue to evolve highlights the subjective aspect of “failure to progress” as a diagnosis; an amount of time elapsed in labor that would have previously caused a doctor to call for a cesarean is now considered “normal.” See *Nation’s Ob-Gyns Take Aim at Preventing Cesareans*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Feb. 19, 2014), <http://www.acog.org/news/news-releases/2014/02/nations-obgyns-take-aim-at-preventing-cesareans> [https://perma.cc/5USQ-3U5T] (announcing new guidelines that allow prolonged early labor, consider cervical dilation of six—instead of four—centimeters the beginning of active labor, and extend the length of the pushing phase, all of which better reflect evidence from scientific research about labor progress); see also Rebecca Dekker, *Friedman’s Curve and Failure to Progress: A Leading Cause of Unplanned Cesareans*, EVIDENCE BASED BIRTH, <http://evidencebasedbirth.com/friedmans-curve-and-failure-to-progress-a-leading-cause-of-unplanned-c-sections/> [https://perma.cc/ZM4E-METX] (last updated Apr. 26, 2017) (discussing the changing standards of failure to progress).

116. See Kukura, *Giving Birth Under the ACA*, *supra* note 46, at 843 & n.254 (discussing how a global payment model in which reimbursement for all prenatal and intrapartum care generally accrues to the provider who is present for the delivery discourages service coordination among providers); see also SAKALA & CORRY, *supra* note 96, at 59–61 (discussing the incentive to control the timing of delivery created by reliance on a global fee payment system for childbirth).

117. See Kukura, *Giving Birth to the ACA*, *supra* note 46, at 843.

Perhaps the clearest example of how maternity care financing creates perverse economic incentives is the reimbursement differential between vaginal and cesarean deliveries. The higher charge for a cesarean delivery—along with increased payment for longer hospitalizations and more related procedures—may encourage physicians to recommend cesareans in the absence of medical necessity.¹¹⁸ Researchers have identified settings where women with private, fee-for-service insurance have cesareans at higher rates than women who are covered by health maintenance organizations or Medicaid, or those who lack insurance altogether.¹¹⁹

Other studies have identified differences in cesarean rates associated with the profit orientation of the hospital or the extent to which providers will get reimbursed more for cesarean deliveries.¹²⁰ One study concluded that a woman who delivers at a for-profit hospital is 17% more likely to have a cesarean birth; for-profit hospitals are more likely to perform cesareans than not-for-profit hospitals, even for patients experiencing low-risk pregnancies.¹²¹ Taken together, this research suggests that the financial interests of hospitals and individual providers influence clinical decisionmaking, even if only subconsciously. This influence interferes with evidence-based practice and increases the risk of harm to patients.

Economic concerns in obstetrics may degrade patient care in other ways as well. In order to remain profitable, obstetrics practices have shortened prenatal appointment times, with 66% of obstetricians reporting that they spend sixteen minutes or less with each patient.¹²² It is now common for patients to rotate through a series of providers in a single obstetrics practice for prenatal care, with no guarantee of which physician will be on call when the patient goes into labor.¹²³ Some hospitals have hired laborists, who are staff physicians who only attend births—meeting the patient for the first time after labor

118. See SAKALA & CORRY, *supra* note 96, at 59–60 (discussing perverse incentives in maternity care payment structure).

119. See Emmett B. Keeler & Mollyann Brodie, *Economic Incentives in the Choice Between Vaginal Delivery and Cesarean Section*, 71 MILBANK Q. 365, 373–74 (1993) (discussing data from California regarding payment sources and cesarean birth rates).

120. See, e.g., Jonathan Gruber & Maria Owings, *Physician Financial Incentives and Cesarean Section Delivery*, 27 RAND J. ECON. 99, 99 (1996) (analyzing declining fertility from 1970–1982 and the rise of cesareans as a way to offset lost profit); Kukura, *Obstetric Violence*, *supra* note 22, at 767–68 (discussing research on Medicaid insureds that found lower cesarean rates where per-patient reimbursement was limited). Research on maternity care systems outside the United States supports the conclusion that economic forces often lead to higher rates of cesarean deliveries and other medical interventions. See Brief of Human Rights in Childbirth et al. as Amicus Curiae in Support of Plaintiff Rinat Dray at 22 n.37, *Dray v. Staten Island Univ. Hosp.*, 75 N.Y.S.3d 59 (N.Y. Sup. Ct. Apr. 11, 2014) (No. 500510/2014) [hereinafter Brief of Human Rights in Childbirth] (citing studies in Greece, Australia, Thailand, and Brazil that found economic incentives influence higher cesarean rates).

121. See Nathanael Johnson, *For-Profit Hospitals Performing More C-Sections*, KAISER HEALTH NEWS (Sept. 13, 2010), <http://khn.org/news/californiawatch-profit-hospitals-performing-more-c-sections/> [https://perma.cc/BP9B-NH74].

122. See Carol Peckham, *Medscape Ob/Gyn Compensation Report 2018*, MEDSCAPE 24 (Apr. 18, 2018), <http://www.medscape.com/slideshow/2018-compensation-ob-gyn-6009662#24> [https://perma.cc/XD3E-R9PR].

123. See, e.g., *Obstetrics/Prenatal Patients*, YALE HEALTH, <http://yalehealth.yale.edu/obstetricsprenatal-patients> [https://perma.cc/DZ7R-F7W4] (last visited Feb. 1, 2021) (describing how physicians share on-call delivery shifts and policies for prenatal visits).

has begun.¹²⁴ While these changes improve quality of life for obstetricians, who are better able to share the burden of being on call, they interfere with the trust relationship between patient and provider. In addition, there is some indication that providers consider demands on staff time and hospital resources when scheduling inductions or cesareans. Research shows that a disproportionate number of babies are born on weekdays during the day, despite the fact that babies born at home without any intervention are more likely to be born between 1:00 a.m. and 5:00 a.m.¹²⁵

2. Fear of Liability & Malpractice Rates

Obstetricians face higher malpractice insurance rates and are sued more often than their colleagues in other practice areas.¹²⁶ Although research suggests that a very small percentage of injuries caused by medical negligence leads to legal claims,¹²⁷ more than three-quarters of OB-GYNs have been sued at least once, and half have faced malpractice lawsuits three times or more.¹²⁸ Obstetrics cases constitute nearly three-quarters of all OB-GYN malpractice insurance losses.¹²⁹ Furthermore, cases involving childbirth produce the highest jury awards among all medical malpractice cases, with a median of \$2.25 million.¹³⁰

Research shows that certain factors increase the likelihood that a physician will be sued, such as poor communication, lack of trust in the physician-patient relationship, patient frustration with brief appointments, and patronizing treatment by physicians.¹³¹ In particular, patients mention desertion by their physicians, devaluing of patients' views, poorly delivered information, and the failure of physicians to understand patient perspectives as reasons they decided to bring malpractice claims.¹³² Such factors reflect the importance of the physician's role as a fiduciary to the patient and the extent to which

124. Phil Galewitz, *Hospitals Look to Laborists To Fill Gaps Left By On-Call Obstetricians*, PBS NEWS HOUR (July 29, 2015, 1:36 PM), <http://www.pbs.org/newshour/health/hospitals-look-laborists-fill-gaps-left-call-obstetricians> [https://perma.cc/899K-S2UX]; see also Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 657: The Obstetric and Gynecologic Hospitalist*, 127 OBSTETRICS & GYNECOLOGY e81, e81–e82 (2016) (explaining the emergence of the OB-GYN hospitalist).

125. Lena H. Sun, *What Time of Day Are Most U.S. Babies Born?*, WASH. POST (May 8, 2015, 11:48 AM), http://www.washingtonpost.com/news/to-your-health/wp/2015/05/08/what-time-of-day-are-most-u-s-babies-born/?utm_term=.2fefe2073ff9 [https://perma.cc/HC9R-MTT5].

126. See Victoria L. Green, *Liability in Obstetrics and Gynecology*, in LEGAL MEDICINE 441, 441 (S. Sandy Dunbar & Marvin H. Firestone eds., 7th ed. 2007) (reporting that 77% of obstetricians and gynecologists have been sued in their careers).

127. See Melissa Patterson, *The Medical Malpractice Crisis: The Product of Insurance Companies and a Threat to Women's Health*, 8 QUINNIPIAC HEALTH L.J. 109, 128 (2004) (“[O]nly 1.53% of patients injured by medical negligence filed malpractice claims.” (quoting Ken Marcus Gatter, *The Continued Existence and Benefit of Medicine's Autonomous Law in Today's Health Care System*, 24 U. DAYTON L. REV. 215, 249 (1999))).

128. Green, *supra* note 126, at 441.

129. Nancy Ostergard, *CRICO Obstetric and Gynecology Claims Review*, FORUM (Risk Mgmt. Found. of the Harv. Med. Insts.), Aug. 1999, at 2, 2.

130. James Gibson, *Doctrinal Feedback and (Un)Reasonable Care*, 94 VA. L. REV. 1641, 1674 (2008).

131. Kukura, *Obstetric Violence*, *supra* note 22, at 771–72 (discussing research on factors leading to medical malpractice liability).

132. See Wendy Levinson, *Physician-Patient Communication: A Key to Malpractice Prevention*, 272 JAMA 1619, 1619–20 (1994) (discussing factors identified in a study of deposition transcripts from obstetrics malpractice cases).

failure to act in a patient's best interest, resulting in betrayal of patient trust, is experienced as harmful by patients.¹³³

Fear of liability leads some physicians to practice defensive medicine, including unwanted and non-evidence-based interventions.¹³⁴ Defensive medicine refers to delivering medical care in a way that includes excessive testing, prescription of unneeded medication, or the recommendation of unnecessary surgery in order to reduce liability risk.¹³⁵ Research suggests that fear of liability prompts physicians to overuse medical intervention during labor and delivery, contributing to the ballooning cesarean rate and declining VBAC rate.¹³⁶ Unnecessary intervention can increase the risk of injury and weaken the physician-patient relationship by interfering with the patient's trust that the physician is always acting in the patient's best interests.¹³⁷

Interestingly, research also suggests that physicians overestimate their risk of being sued (and the risk that a prospective plaintiff will recover damages as a result of the litigation), which suggests that provider education about the real risks of malpractice exposure might be a useful intervention to reduce the unnecessary safety and financial costs associated with defensive medicine in obstetrics.¹³⁸ Ultimately, physician anxiety about potential malpractice exposure negatively impacts clinical practice, health outcomes, and the patient experience. Not only does fear of liability help explain the problems with modern maternity care in the United States, but it also suggests that any meaningful solution must address defensive medicine and its relationship to health outcomes.

133. See generally Elizabeth Kukura, *Obstetric Violence Through a Fiduciary Lens*, in *CHILDBIRTH, VULNERABILITY AND LAW: EXPLORING ISSUES OF VIOLENCE AND CONTROL*, *supra* note 36, at 204 (discussing how principles of fiduciary law can be useful in examining obstetric violence).

134. Kukura, *Obstetric Violence*, *supra* note 22, at 771–74.

135. See, e.g., Laura D. Hermer & Howard Brody, *Defensive Medicine, Cost Containment, and Reform*, 25 J. GEN. INTERNAL MED. 470, 470 (2010); see also MASS. MED. SOC'Y, INVESTIGATION OF DEFENSIVE MEDICINE IN MASSACHUSETTS 4–5 (2008) (finding that approximately 40% of the specialist referrals ordered by OB-GYNs and 33% of the CT scans ordered by OB-GYNs, emergency physicians, and family practitioners were medically unnecessary, and 35% of OB-GYNs reported that liability concerns affected the care they provide “a lot”).

136. See Y. Tony Yang, David M. Studdert, S.V. Subramanian & Michelle M. Mello, *Does Tort Law Improve the Health of Newborns, or Miscarry? A Longitudinal Analysis of the Effect of Liability Pressure on Birth Outcomes*, 9 J. EMPIRICAL LEGAL STUD. 217, 218–19 (2012) (concluding that results “strongly suggest that liability pressures influence obstetrical practice” and suggesting that a decrease in OB-GYN insurance premiums would be associated with fewer cesareans and more VBACs); Y. Tony Yang, Michelle M. Mello, S.V. Subramanian & David M. Studdert, *Relationship Between Malpractice Litigation Pressure and Rates of Cesarean Section and Vaginal Birth After Cesarean Section*, 47 MED. CARE 234, 234 (2009) (concluding that less threat of litigation would result in fewer cesarean deliveries and lower total delivery costs). But see David Dranove & Yasutora Watanabe, *Influence and Deterrence: How Obstetricians Respond to Litigation Against Themselves and Their Colleagues*, 12 AM. L. & ECON. REV. 69, 69 (2010) (concluding that data do not show that fear of litigation has driven the increase in cesarean rates nationwide, despite finding cesarean rates rise temporarily after a physician is notified of a lawsuit).

137. Elizabeth Swire Falker, *The Medical Malpractice Crisis in Obstetrics: A Gestalt Approach to Reform*, 4 CARDOZO WOMEN'S L.J. 1, 15 n.86 (1997).

138. See Ann G. Lawthers, A. Russell Localio, Nan M. Laird, Stuart Lipsitz, Liesi Hebert & Troyen A. Brennan, *Physicians' Perceptions of the Risk of Being Sued*, 17 J. HEALTH POL., POL'Y & L. 463, 469 tbl.1 (1992) (finding that physicians practicing high-risk obstetrics overestimate their chances of being sued by a factor of 1.6).

3. Declining Workforce

Professional pressure on obstetricians—or the perception of such pressure—has led to declining numbers of physicians choosing to pursue obstetrics as a specialty. Residency programs have experienced a decline in interest among prospective trainees at the same time that more obstetricians have stopped or reduced their practices due to perceived malpractice risks.¹³⁹ The average age for physicians to stop practicing obstetrics is forty-eight.¹⁴⁰ Two influential reasons for early retirement are the increasing cost of liability insurance premiums and insufficient net compensation.¹⁴¹ Notably, the American College of Obstetricians and Gynecologists (ACOG) estimates that between 40–75% of OB-GYNs experience some form of burnout.¹⁴²

As a result of these factors, analysts predict that, by 2030, the United States will have a shortage of between nine thousand and nearly sixteen thousand obstetricians to meet the needs of the projected population.¹⁴³ The gap in the workforce may increase even further after 2030 because the female population is expected to increase 36% from 2010 to 2050, while the number of obstetricians is expected to remain at its current level.¹⁴⁴ Currently, medical schools graduate approximately twelve hundred physicians from OB-GYN residency programs annually.¹⁴⁵ As this article goes to print, approximately half of all counties in the United States lack an obstetrician.¹⁴⁶

As is the case with many health care specialties, geography matters. The obstetrics workforce shortage has a disproportionate impact on rural areas.¹⁴⁷ Although provider consolidation and other innovations have softened the adverse impact of workforce shortages in other areas of medicine,¹⁴⁸ the same is not true for obstetrics, given the individualized, hands-on nature of the care provided.¹⁴⁹ In recent years, ACOG and the American College of Nurse-Midwives (ACNM) have issued several joint statements emphasizing the value of collaboration between physicians and nurse-midwives, despite

139. See Jennifer Silverman, *Malpractice Crisis Blamed; Fewer U.S. Seniors Match to OB.GYN. Residency Slots: The Fill Rate for this Group Falls to 65.1%*, OB GYN NEWS, Apr. 1, 2004, GALEIA115769509.

140. WILLIAM F. RAYBURN, *THE OBSTETRICIAN-GYNECOLOGIST WORKFORCE IN THE UNITED STATES: FACTS, FIGURES, AND IMPLICATIONS* 2011, at 104 tbl.7-3 (2011).

141. *Id.* at 101–02.

142. *Why Ob-Gyns Are Burning Out*, AM. COLL. OBSTETRICS & GYNECOLOGY (Oct. 28, 2019), [http://www.acog.org/news/news-articles/2019/10/why-ob-gyns-are-burning-out#:~:text=Physicians%20have%20burnout%20rates%20that,sense%20of%20worth\).%22%20](http://www.acog.org/news/news-articles/2019/10/why-ob-gyns-are-burning-out#:~:text=Physicians%20have%20burnout%20rates%20that,sense%20of%20worth).%22%20) [https://perma.cc/3S6E-GGHX].

143. See RAYBURN, *supra* note 140, at 121.

144. *Id.* at 137.

145. See *id.* at 2.

146. *Id.* at 45.

147. See Katy B. Kozhimannil, Michelle M. Casey, Peiyin Hung, Xinxin Han, Shailendra Prasad & Ira S. Moscovice, *The Rural Obstetric Workforce in US Hospitals: Challenges and Opportunities*, 31 J. RURAL HEALTH 365, 365–66 (2015).

148. See, e.g., Lenny Bernstein, *U.S. Faces 90,000 Doctor Shortage by 2025, Medical School Association Warns*, WASH. POST (Mar. 3, 2015, 1:54 PM), http://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/?utm_term=.99d34f580b18 [https://perma.cc/2R46-RDCH] (discussing changes in the medical profession that suggest projected shortages in primary care may not occur).

149. See Brody, *supra* note 19 (discussing the particular reasons for the shortage of obstetricians).

the fact that disagreement over home birth and other issues persists.¹⁵⁰ This reflects a growing awareness within mainstream medicine that midwives are necessary for meeting patient needs in the absence of a major influx of new obstetricians.

E. *Obstetric Violence & Emotional Trauma*

Because high-intervention birth is the norm in the modern U.S. health care system, women who want to labor and deliver without intervention sometimes encounter resistance from medical providers whose default is intervention.¹⁵¹ In some circumstances, this leads to coercion in maternity care decisionmaking, with providers insisting on certain procedures or engaging in tactics to convince a woman to accept unwanted medical treatment.¹⁵² Such coercion may range from scare-tactic warnings about adverse outcomes—often referred to as playing the “dead baby” or “exploding uterus” card, a sharp contrast to the values of informed consent and shared decisionmaking at the heart of U.S. medical care¹⁵³—to threats to seek a court order or report a woman to child welfare authorities for child abuse if she does not consent to labor induction or a cesarean.¹⁵⁴ Some childbearing women experience other forms of mistreatment at the hands of their health care providers, including forced surgeries, physical violence, and humiliation—a phenomenon advocates increasingly refer to as obstetric violence.¹⁵⁵

The mistreatment of pregnant people during labor and delivery not only violates the legal and ethical obligations of health care providers but also increases the risk of adverse health consequences for birthing people. A growing number of women are reporting experiences of birth trauma, using the language of “trauma” and “rape” to describe their

150. See, e.g., AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS & AM. COLL. OF NURSE-MIDWIVES, JOINT STATEMENT OF PRACTICE RELATIONS BETWEEN OBSTETRICIAN-GYNECOLOGISTS AND CERTIFIED NURSE MIDWIVES/CERTIFIED MIDWIVES (2018), <http://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/joint-statement-of-practice-relations-between-ob-gyns-and-cnms> [https://perma.cc/T8ZY-HCWV].

151. See Elizabeth Kukura, *Birth Conflicts: Leveraging State Power To Coerce Health Care Decision-Making*, 47 U. BALT. L. REV. 247, 249–50 (2018) [hereinafter Kukura, *Birth Conflicts*].

152. *Id.*

153. See JENNIFER BLOCK, PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE 91–92 (2007).

154. See Kukura, *Birth Conflicts*, *supra* note 151, at 249–50; Kukura, *Obstetric Violence*, *supra* note 22, at 798.

155. See generally Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016) (discussing the legal issues surrounding obstetric and gender-based violence); Kukura, *Obstetric Violence*, *supra* note 22 (discussing various ways providers coerce pregnant women, including through court orders); Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH, no. 77, 2019, at 2 (analyzing the prevalence of obstetric violence among pregnant women in the United States); Olivia Miltner, *‘It Felt Like I Had Been Violated’: How Obstetric Violence Can Traumatize Patients*, REWIRE (Jan. 23, 2019, 7:30 AM), <http://rewire.news/article/2019/01/23/it-felt-like-i-had-been-violated-how-obstetric-violence-can-traumatize-patients/> [https://perma.cc/X9YZ-8L4S] (presenting individual women’s experiences with obstetric violence); Sarah Yahr Tucker, *There Is a Hidden Epidemic of Doctors Abusing Women in Labor*, DOULAS SAY, VICE (May 8, 2018, 12:08 PM), http://www.vice.com/en_us/article/evqew7/obstetric-violence-doulas-abuse-giving-birth [https://perma.cc/7L4A-WMNR] (discussing the increasing awareness around obstetric violence).

treatment by health care providers during labor and delivery.¹⁵⁶ One study concluded that up to 9% of new mothers satisfy the clinical criteria for post-traumatic stress disorder.¹⁵⁷ Other research indicates that birth trauma was most closely associated with being coerced to consent to treatment, rather than the seriousness of any complications arising from the birth itself.¹⁵⁸ Emotional trauma experienced during childbirth may have lasting negative impacts on postpartum bonding, healing, and maternal and newborn well-being, including the ability to breastfeed; the likelihood of such outcomes is increased if the trauma is left unaddressed and untreated.¹⁵⁹

As with all areas of health care, the experience of receiving maternity care is a highly personal one—with various factors shaping whether a patient feels listened to, respected, well cared for, and, ultimately, whether the patient trusts the provider. The fact that many women report excellent maternity care experiences and feel satisfied with their hospital experience, care provider, and degree of medical intervention does not negate the fact that many other pregnant and birthing people experience disrespect, coercion, unnecessary intervention, lack of trust, or loss of agency while giving birth—often resulting in real physical and emotional harm. The challenge is for health care providers, policymakers, and other stakeholders to hear both the positive and negative experiences and make necessary adjustments to ensure that all pregnant people can access care that is appropriate for them. This task is complicated by public discourse about childbirth that conveys judgment about certain individual choices—such as whether to forego pain medication or seek an early epidural, or whether to birth at home in a tub or schedule a cesarean¹⁶⁰—and often leaves little space for open discussion about the kinds of maternity care reforms that can enable everyone to make choices that are appropriate for them and have those decisions respected.

156. See Brief of Human Rights in Childbirth, *supra* note 120, at 33–35 (recounting birth stories of women who experienced trauma and suffered flashbacks and nightmares about giving birth); Penny Simkin, *Birth Trauma: Definition and Statistics*, PREVENTION & TREATMENT OF TRAUMATIC CHILDBIRTH, <http://patch.org/resource-guide/traumatic-births-and-ptsd-definition-and-statistics/> [<https://perma.cc/MP54-U5RU>] (last visited Feb. 1, 2021).

157. Cheryl Tatano Beck, Robert K. Gable, Carol Sakala & Eugene R. Declercq, *Posttraumatic Stress Disorder in New Mothers: Results from a Two-Stage U.S. National Survey*, 38 BIRTH 216, 217 (2011) (finding that between 1.7% and 9% of mothers suffer from post-traumatic stress disorder); see also Cheryl Tatano Beck, *Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath*, 53 NURSING RES. 216, 216 (2004) (finding that between 1.5% and 6% of mothers in New Zealand, the United States, Australia, and the United Kingdom suffer from post-traumatic stress disorder).

158. See Kukura, *Obstetric Violence*, *supra* note 22, at 756–57.

159. *Id.* (discussing the negative health implications of experiencing birth trauma); see also Brief of Human Rights, *supra* note 120, at 34–36 (describing types of emotional suffering that women may experience after traumatic births, including humiliation, degradation, and shame); Michaels, *supra* note 68, at 71–72 (noting that a high incidence of women experiencing birth trauma has been consistent across decades but that there has been an evolution from identifying the cause of the trauma as their own psychological shortcomings to framing the trauma as avoidable harm caused by maternity care practices).

160. The opportunity to make choices that may incur severe public judgment continues after birth, with decisions about breastfeeding and formula feeding, circumcision, and vaccination all highly contested in the broader culture. See, e.g., JENNIFER A. REICH, *CALLING THE SHOTS: WHY PARENTS REJECT VACCINES* (2016) (discussing the debate regarding whether to vaccinate one's children).

II. MIDWIFERY AS A (PARTIAL) SOLUTION

One consequence of the marginalization of midwives over the twentieth century is that public familiarity with midwifery is relatively low, even with the popularity of the PBS television series *Call the Midwife*.¹⁶¹ And yet, midwives provide a model of pregnancy-related care that satisfies the health care demands of both consumers and policymakers. Midwifery care is patient-centered, prioritizing trust and relationship building, informed consent, and holistic well-being of the pregnant client and their family.¹⁶² Its starting point is a childbirth philosophy that assumes most bodies with uteruses are capable of physiologic birth without intervention, and the role of the midwife as care provider is to provide information and support, guiding the pregnant person through labor and delivery.¹⁶³ Midwifery care is also cost-effective, with savings realized due to the lower reimbursement rates of midwives, the avoided cost of fewer interventions, and lower rates of complications.¹⁶⁴

At the systems level, the choice between physicians and midwives is not simply an either/or policy decision. An ideal model for greater midwife participation in U.S. childbirth is a model of interprofessional collaboration between midwives, physicians, and other medical specialists—marked by effective communication among the team of providers and the ability to transfer the patient seamlessly as care needs evolve during the pregnancy or delivery. While some people feel safest giving birth with a physician-attendant, others want and would benefit from midwifery care. Various European nations, in fact, offer successful models for how to harness the benefits of midwives as primary maternity care providers while preserving access to obstetricians for higher-risk situations or where the patient prefers physician-led care.¹⁶⁵

Part II.A describes the Midwives Model of Care, explaining the types of midwives licensed in the United States and how their philosophy and practice differ from professionals working within the medical model of childbirth. Part II.B details research findings on the health and safety of midwifery care and is followed by a discussion of the cost-effectiveness of midwifery in Part II.C. Finally, Part II.D offers various individual and collective benefits that would result from greater promotion and integration of midwifery into mainstream maternity care.

161. See Wendy C. Budin, *The Truth About Midwives*, 22 J. PERINATAL EDUC. 63, 63–64 (2013).

162. See *infra* Part II.A for a discussion of the characteristics of midwife care.

163. See *About Us: Normal Physiologic Birth*, MIDWIVES ALL. OF N. AM., <http://mana.org/about-midwives/normal-physiologic-birth> [<https://perma.cc/H4CS-5TFE>] (last visited Feb. 1, 2021) (identifying midwives' expertise "in supporting women's innate capacities to give birth").

164. See *infra* Part II.C a discussion of the cost-effectiveness of midwifery.

165. See, e.g., BIRTH MODELS THAT WORK, *supra* note 40, at 31–51 (discussing the Dutch birth model); see also *Innovative Responses to Maternal Mortality: Hearing Before the Joint Senate and House Democratic Policy Committee*, 2020 Leg., 203rd Sess. (Pa. 2020) (statement by Dr. Mark Woodland, Chair, Dep't of Obstetrics & Gynecology, Reading Hospital) (advocating for interprofessional teams in maternity care and noting that seventeen countries had effectively reduced their maternal mortality rates by using an "army of nurse midwives").

A. *Midwives Model of Care*

Midwives are careful to distinguish midwifery from the practice of medicine.¹⁶⁶ Whether they conceive of themselves as practicing a craft, an ancient art, or a model of care, it is clear that midwives do not practice medicine—and the noninterventionist and patient-centered orientation of midwifery has attracted a growing number of pregnant people.¹⁶⁷ The Midwives Model of Care includes “monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle[;] providing the mother/birthing parent with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support[;] minimizing technological interventions[;] and identifying and referring women/birthing people who require obstetrical attention.”¹⁶⁸

Midwifery care is appropriate for people experiencing low-risk pregnancies, and midwives are trained to identify pregnant people with health conditions or complications and refer them for more specialized care.¹⁶⁹ However, in areas where interprofessional tension is high, patients sometimes report encountering hostility from medical providers who learn that the patient had begun prenatal care with a midwife.¹⁷⁰ Before and after the birth, midwifery care is characterized by longer prenatal appointments, attention to the psychosocial needs of the pregnant person and immediate family, counseling about nutrition and healthy habits to support maternal and fetal health, multiple postpartum appointments (often including home visits), and lactation support.¹⁷¹

Intrapartum care typically involves waiting for spontaneous labor to begin, continuous labor support, intermittent monitoring of fetal heart tones (rather than continuous EFM), reliance on natural pain relief methods (including submersion in water to ease the intensity of contractions), use of mobility and squatting positions to facilitate productive contractions, and waiting for the urge to push (rather than pushing coached

166. See, e.g., Suarez, *supra* note 67.

167. See Santa Cruz, *supra* note 37.

168. *About Us: The Midwives Model of Care*, MIDWIVES ALL. OF N. AM., <http://mana.org/about-midwives/midwifery-model> [<https://perma.cc/VL4F-Y4E4>] (last visited Feb. 1, 2021). There is disagreement with the midwifery community about whether to use “women” or the more inclusive “pregnant people” to refer to clients. See *id.*

169. Suarez, *supra* note 67, at 319.

170. Saraswathi Vedam, Lawrence Leeman, Melissa Cheyney, Timothy J. Fisher, Susan Myers, Lisa Kane Low & Catherine Ruhl, *Transfer from Planned Home Birth to Hospital: Improving Interprofessional Collaboration*, 59 J. MIDWIFERY & WOMEN’S HEALTH 624, 629 (2014).

171. See, e.g., Riddle Hospital, *Having a Midwife and an OB/GYN, Best of Both Worlds*, MAIN LINE HEALTH: WELL AHEAD BLOG (Mar. 25, 2019), <http://www.mainlinehealth.org/blog/2019/03/25/having-a-midwife-and-an-obgyn> [<https://perma.cc/TE8N-G7SM>] (noting that the longer prenatal appointments available with a midwife allow the opportunity to focus on counseling).

by a third party).¹⁷² Midwife-attended births involve lower rates of induction and cesarean (after transfer to the hospital)¹⁷³ than physician-attended births.¹⁷⁴

While the basic philosophy of midwifery is consistent among different types of midwives, there are various credentials and licensing statuses that complicate the midwifery landscape in the United States. There are three national credentials: the Certified Professional Midwife (CPM), the Certified Nurse Midwife (CNM), and the Certified Midwife (CM).¹⁷⁵

CPMs are autonomous midwives trained to attend out-of-hospital births either in birth centers or at home.¹⁷⁶ Their credential is granted by the North American Registry of Midwives (NARM), which requires midwifery education either through formal programs accredited by the Midwifery Education Accreditation Council or through a portfolio evaluation process. NARM administers the national exam required to receive the CPM and also monitors continuing education for CPMs.¹⁷⁷ As of October 2020, there were two thousand five hundred CPMs with active certification in the United States.¹⁷⁸ As of December 2020, CPMs can practice legally in thirty-six states.¹⁷⁹

By contrast, CNMs receive training first as registered nurses and then undergo specialized training in midwifery; a graduate degree has been required to earn the CNM since 2010.¹⁸⁰ CNMs must graduate from a nurse-midwifery education program that is accredited by the Accreditation Commission for Midwifery Education (ACME) and pass a national certification exam.¹⁸¹ Trained to attend births in hospitals, freestanding birth

172. See, e.g., Dreger, *supra* note 87.

173. A pregnant person who intends to deliver at home or in a freestanding birth center may decide to transfer to a hospital during labor if the need for medical intervention arises. While transfer may be necessary when either the laboring person or baby (or both) develop complications, the decision to seek hospital care may also reflect nonemergency reasons such as the desire for pain medication. See generally HOME BIRTH SUMMIT, BEST PRACTICE GUIDELINES: TRANSFER FROM PLANNED HOME BIRTH TO HOSPITAL, http://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuideLines.pdf [<https://perma.cc/YQ2D-BQJT>] (last visited Feb. 1, 2021) (outlining guidelines for both home and hospital-based providers to conduct transfers during labor).

174. See *infra* Part II.B for a discussion of the research on the positive health impact of midwife-led care during childbirth.

175. AM. COLL. OF NURSE-MIDWIVES, COMPARISON OF CERTIFIED NURSE-MIDWIVES, CERTIFIED MIDWIVES, CERTIFIED PROFESSIONAL MIDWIVES CLARIFYING THE DISTINCTIONS AMONG PROFESSIONAL MIDWIFERY CREDENTIALS IN THE U.S. (2017), <http://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf> [<https://perma.cc/5325-FAQ4>] [hereinafter ACNM, MIDWIFE COMPARISON CHART].

176. *Id.*

177. *Certification: The CPM Credential*, N. AM. REGISTRY OF MIDWIVES, <http://narm.org/certification/> [<https://perma.cc/5TTP-ADP4>] (last visited Feb. 1, 2021).

178. Email from Ida Darragh, CPM, LM, Member of N. Am. Registry of Midwives Bd., to author (Oct. 23, 2020, 8:30 PM) (on file with author).

179. *CPMs Legal Status by State*, BIG PUSH FOR MIDWIVES, http://pushformidwives.nationbuilder.com/cpms_legal_status_by_state [<https://perma.cc/5CGN-DBE7>] (last visited Feb. 1, 2021). See also *infra* Part III.B.1 for a discussion of the legislative hostility around the licensing of CPMs in the United States.

180. See ACNM, MIDWIFE COMPARISON CHART, *supra* note 175.

181. *Id.*

centers, and at home, CNMs are licensed in all fifty states.¹⁸² As of February 2019, there were 12,218 CNMs practicing in the United States.¹⁸³

In addition, the American College of Nurse-Midwives wanted to create its own direct-entry midwifery credential (i.e., for midwives without nursing training) and thus established the CM credential for people who have a background in a health-related field other than nursing, graduate from an ACME-accredited midwifery program, and take the national certification exam available to CNMs.¹⁸⁴ Like CNMs, CMs are trained to attend births in hospitals, freestanding birth centers, or at home. As of February 2019, there were 102 CMs recognized in the United States, and they were able to receive licenses in six states.¹⁸⁵

Separate from their credentials, midwives may also have a designation that indicates whether they hold a state license from the relevant licensing body; this designation is often “licensed midwife” but may vary by jurisdiction.¹⁸⁶ Some midwives practice without a national credential or license, perhaps due to philosophical objections or practical barriers.¹⁸⁷ They may be called direct-entry midwives, traditional midwives, or lay midwives.¹⁸⁸

The Midwives Model of Care stands in stark contrast to the medical model of childbirth that dominates mainstream maternity care in the United States. Under the medical model, birth is a condition to be managed; providers operate in an environment

182. *The Credential CNM and CM*, AM. COLL. NURSE-MIDWIVES, <http://www.midwife.org/The-Credential-CNM-and-CM> [https://perma.cc/JZY2-HL7A] (last visited Feb. 1, 2021).

183. AM. COLL. NURSE-MIDWIVES, ESSENTIAL FACTS ABOUT MIDWIVES (2019), <http://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007531/EssentialFactsAboutMidwives-UPDATED.pdf> [https://perma.cc/95F6-3GQN] [hereinafter ACNM, ESSENTIAL FACTS].

184. ACNM, MIDWIFE COMPARISON CHART, *supra* note 175.

185. ACNM, ESSENTIAL FACTS, *supra* note 183, at 1.

186. *See, e.g., Midwifery - Questions & Answers*, OFF. OF THE PROFS., <http://www.op.nysed.gov/prof/midwife/midwifeqa.htm> [https://perma.cc/N6FD-HXNJ] (last updated Apr. 7, 2014) (describing the “Licensed Midwife” or “LM” designation under New York law).

187. *See, e.g., NAN STRAUSS, CHOICES IN CHILDBIRTH & EVERY MOTHER COUNTS, MAXIMIZING MIDWIFERY TO ACHIEVE HIGH-VALUE MATERNITY CARE IN NEW YORK* 38 (2018) (discussing barriers to midwifery licensure in New York). One line of critique calls for avoiding participation in state licensing regimes as a form of resistance to the colonization of traditional birth practices that belong to the community and were transmitted by “granny” midwives. *See, e.g.,* Keisha L. Goode, *Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism* 48 (2014) (unpublished Ph.D. dissertation, City University of New York), http://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1422&context=gc_etds [https://perma.cc/6VHG-NFQU] (“We recognize that the process of licensing and certifying midwives after the 1960s in many cases served to marginalize and exclude practicing midwives in communities of color. . . . We posit that white midwives’ failure to acknowledge this history while laying claim to ‘traditional knowledge’ from the 1970s onward is an act of violence, erasing midwives of color from the past and creating an ‘innocent’ present for white-dominated midwifery.” (quoting *Anti-Racism and Anti-Oppression Work in Midwifery* (AROM), posted in Midwives Alliance of North America (MANA) Midwives of Color Section Committee Post Resignation Public Forum, FACEBOOK (June 8, 2012)); *see also* RAYMOND G. DE VRIES, *MAKING MIDWIVES LEGAL: CHILDBIRTH, MEDICINE, AND THE LAW*, at xvi (2d ed. 1996) (arguing that regulation effectively destroys the aspects of midwifery that distinguish it from the medical establishment).

188. *See* Robbie E. Davis-Floyd, *The Ups, Downs, and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice, and Education*, in *PATHS TO BECOMING A MIDWIFE: GETTING AN EDUCATION* (Jan Tritten & Kelly Moyer eds., 1998) (discussing evolution of the term “lay midwife”); MANA, *Types of Midwives*, *supra* note 43.

that understands delivery as rife with potential complications and assumes active management of labor through continuous monitoring, artificial acceleration of labor, and use of pharmacological pain relief measures are the best ways to lessen the risk.¹⁸⁹ Prenatal care provided by physicians usually involves brief appointments to monitor vital signs and check fetal heart rate, with patients rotating through different obstetricians or nurse practitioners in the practice at each subsequent visit.¹⁹⁰ During labor, the pregnant person is monitored by nurses—in person and remotely through EFM data sent to a centralized location at the nurses' station—and the physician visits periodically, usually to perform a manual inspection of her cervix to diagnose labor progress.¹⁹¹ The laboring person is often attended by a physician she has never met, either because someone other than her own obstetrician is on call when labor begins or because the hospital employs laborists to perform shift work in the hospital.¹⁹²

Medically-managed births tend to take place in more impersonal environments than midwife-attended births—with hospitals limiting who can be present during delivery and featuring rooms with medical equipment and harsh lighting. Under the medical model of birth, patients are discharged anywhere from two to four days after giving birth, depending on the nature of the delivery and any complications.¹⁹³ The next time the patient seeks a physician is typically six weeks later at the one postpartum visit that is regularly scheduled.¹⁹⁴

Differences in the culture of birth under the midwifery and medical models are reflected in the language providers use. While midwives describe themselves as “catching babies” and “attending births” and their clients as the ones “delivering babies,” physicians typically characterize their role as “delivering babies.”¹⁹⁵ Feminist

189. See, e.g., JESSICA MITFORD, *THE AMERICAN WAY OF BIRTH* 7–8 (1992) (describing the author's experiences under the medical model of care).

190. *What Happens During Prenatal Visits?*, NAT'L INSTS. OF HEALTH, <http://www.nichd.nih.gov/health/topics/preconceptioncare/conditioninfo/prenatal-visits> [https://perma.cc/7AW8-ANXF] (last visited Feb. 1, 2021).

191. This allows nurses to monitor multiple laboring women simultaneously, which enables more efficient staffing for hospitals. See Lisa Heelan, *Fetal Monitoring: Creating a Culture of Safety with Informed Choice*, 22 J. PERINATAL EDUC. 156, 158 (2013).

192. See *supra* Part I.D.1 for a discussion on the perverse economic incentives promoted by the medical model of childbirth.

193. See *Maternity Length of Stay Rules*, NAT'L CONF. ST. LEGISLATURES (Apr. 23, 2018), <http://www.ncsl.org/research/health/final-maternity-length-of-stay-rules-published.aspx> [https://perma.cc/BG4V-QWML] (discussing federal law that prohibits the restriction of mothers' and newborns' insurance coverage for hospital stays after childbirth to no less than forty-eight hours for vaginal delivery or ninety-six hours for cesarean delivery).

194. See *ACOG Redesigns Postpartum Care*, AM. COLL. OBSTETRICIANS & GYNECOLOGISTS (Apr. 23, 2018), <http://acog.org/news/news-releases/2018/04/acog-redesigns-postpartum-care> [https://perma.cc/7PBX-C2PK]. When ACOG issued new guidelines in May 2018 recommending that patients have an initial postpartum assessment within three weeks of giving birth, it noted that the “fourth trimester” is critical for maternal and infant well-being. Am. Coll. of Obstetricians & Gynecologists, *Committee Opinion No. 736: Optimizing Postpartum Care*, 131 OBSTETRICS & GYNECOLOGY e140, e140 (2018). The three-week recommendation has not yet become standard practice in most care settings.

195. See Melissa Garvey, *Midwives Don't Deliver? What's the Catch?*, MIDWIFE CONNECTION (Feb. 4, 2010), <http://acnm-midwives.blogspot.com/2010/02/midwives-dont-deliver-whats-catch.html> [https://perma.cc/36S2-J93J] (explaining the preference for saying “catch a woman's baby” because it “acknowledges that the woman does the work of birthing the baby”).

commentators have further critiqued the language used to describe cesarean deliveries as diminishing the role of the pregnant person's reproductive labor and reducing bodies to objects upon which medicine is performed; common hospital shorthand refers to a cesarean section as "sectioning her," with physicians "performing" the cesarean rather than women "delivering."¹⁹⁶ Others have criticized language that refers to what pregnant people are "allowed" to do with their bodies during childbirth, as if patients must seek permission from their doctors to wait for labor to start spontaneously, use the bathroom during labor, or hold their babies immediately after birth.¹⁹⁷

B. Midwifery's Health & Safety Record

Midwifery opponents often argue that midwife care is less safe than physician care, drawing on racist historical stereotypes of midwives as dirty and illiterate immigrants combined with mischaracterizations of the research literature on midwifery outcomes.¹⁹⁸ In fact, a sizable body of research confirms that midwifery care is safe and effective for people experiencing low-risk pregnancies.¹⁹⁹ A 2012 metareview of research on midwife-led care found no adverse outcomes associated with midwifery and also reported evidence of better outcomes on several maternal health measures, a reduction in the number of procedures used during labor, and increased satisfaction with care for women receiving midwife-led care.²⁰⁰ A 2016 Cochrane review examining research on hospital births in advanced health care systems (the United Kingdom, Ireland, Australia, and Canada) concluded that women attended by midwives were less likely to require pain medication in labor, less likely to experience pre-term birth, and less likely to suffer

196. See, e.g., ROBBIE E. DAVIS-FLOYD, *BIRTH AS AN AMERICAN RITE OF PASSAGE* 56–59 (2d ed. 2003).

197. See, e.g., Cristen Pascucci, *You're Not Allowed To Not Allow Me*, BIRTH MONOPOLY (June 17, 2014), <http://birthmonopoly.com/allowed/> [<https://perma.cc/DP36-KMLP>] (discussing how the language of being "allowed" used by medical providers shapes individual birth experiences and the culture of birth).

198. The study most often cited to argue that home births assisted by midwives are dangerous was published by ACOG in the 1970s. The ACOG authors concluded that "out-of-hospital births pose a two to five times greater risk to a baby's life" but failed to note that the dataset misleadingly included miscarriages, premature births, taxi cab deliveries, and other unplanned out-of-hospital births, along with planned home births attended by trained midwives. Suarez, *supra* note 67, at 354 (quoting Press Release, Am. Coll. of Obstetricians & Gynecologists, Health Department Data Shows Danger of Home Births (Jan. 4, 1978)). As sociologist Raymond De Vries has highlighted, the ACOG study was not only misleading but also unscientific. See DE VRIES, *supra* note 187, at 134–35. For another example of research that opponents of home birth cite to cast doubt on its safety, despite the fact that the study uses unreliable birth certificate data and suffers from other methodological flaws, see Amos Grünebaum, Laurence B. McCullough, Katherine J. Sapa, Robert L. Brent, Malcolm I. Levene, Birgit Arabin & Frank A. Chervenak, *Early and Total Neonatal Mortality in Relation to Birth Setting in the United States, 2006–2009*, 211 AM. J. OBSTETRICS & GYNECOLOGY 390.e1, 390.e3 (2014).

199. In their comprehensive compilation of the evidence about clinical practices and hospital policies related to childbirth, Henci Goer and Amy Romano offer an important metacritique about how research agendas are shaped by the norms of the profession. They argue that, because interventionism has become the default for maternity care, the assumption of intervention shapes how research questions are crafted and implemented. This research orientation makes it difficult to collect useful data on the benefits of not intervening, such as, for example, when a study examines which of two interventions provides the better outcome but fails to capture how either intervention performs against undisturbed physiologic labor. See GOER & ROMANO, *supra* note 102, at 16–18.

200. Katy Sutcliffe, Jenny Caird, Josephine Kavanagh, Rebecca Rees, Kathryn Oliver, Kelly Dickson, Jenny Woodman, Elain Barnett-Paige & James Thomas, *Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews*, 68 J. ADVANCED NURSING 2376, 2384 (2012).

a miscarriage before twenty-four weeks of pregnancy.²⁰¹ A 2011 systematic review published in *Nursing Economics* reported that midwife-led births were less likely to result in a cesarean than physician-only care.²⁰² Women receiving midwife-led care also had lower rates of episiotomies, induced labor, and vaginal tearing during delivery.²⁰³ A 1998 systematic review that compared prenatal care by midwives and general practitioners with obstetricians concluded that use of midwives and general practitioners was associated with a reduced likelihood of pregnancy-induced hypertension and preeclampsia,²⁰⁴ greater satisfaction with the labor and delivery experience, and lower costs.²⁰⁵

Other research confirms that midwifery care is associated with fewer interventions than physician-led care. A 2004 systematic review that compared midwifery care in freestanding birth centers with obstetrician-led care in hospital settings found that women who received midwifery care had a lower likelihood of episiotomy and cesarean surgery.²⁰⁶ An earlier systematic review, published in 1998, found that women attended by midwives were less likely to experience labor induction, labor augmentation, continuous EFM, pain medication, vaginal birth assisted by vacuum or forceps, and episiotomy.²⁰⁷ A meta-analysis of fifteen studies comparing certified nurse-midwife care with physician-led care concluded that midwife care was associated with less use of analgesia, anesthesia, intravenous fluids, EFM, artificial rupture of membranes, and use of forceps, along with a greater likelihood of spontaneous vaginal birth and reduced low birth weight among newborns.²⁰⁸

A subset of the research literature on midwifery care focuses on the safety and health impact of home birth in particular, confirming that midwife-attended home birth is a reasonable choice for people experiencing low-risk pregnancies. The Midwives Alliance of North America study, which includes data on approximately seventeen thousand midwife-led births, is the largest existing analysis of planned home births in

201. Jane Sandall, Hora Soltani, Simon Gates, Andrew Shennan & Declan Devane, *Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women*, COCHRANE DATABASE OF SYS. REVS., 2016, at 1, 2–4.

202. Robin P. Newhouse et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 230, 243 tbl.5b (2011).

203. *Id.* at 244 tbl.5b.

204. Preeclampsia is a condition in pregnancy characterized by high blood pressure and damage to another organ system, such as the liver and kidneys. It can lead to serious (including fatal) complications for the pregnant person and fetus. *Preeclampsia*, MAYO CLINIC, <http://www.mayoclinic.org/diseases-conditions/preeclampsia/symptoms-causes/syc-20355745> [<https://perma.cc/3T8C-YXSR>] (last visited Feb. 1, 2021).

205. See Dina Khan-Neelofur, Metin Gülmezoglu & José Villar, *Who Should Provide Routine Antenatal Care for Low-Risk Women, and How Often? A Systematic Review of Randomised Controlled Trials*, 12 PAEDIATRIC & PERINATAL EPIDEMIOLOGY 7, 18–19 (1998).

206. See Denis Walsh & Soo M. Downe, *Outcomes of Free-Standing, Midwife-Led Birth Centers: A Structured Review*, 31 BIRTH 222, 225–27 (2004).

207. Ulla Waldenström & Deborah Turnbull, *A Systematic Review Comparing Continuity of Midwifery Care with Standard Maternity Services*, 105 BRIT. J. OBSTETRICS & GYNECOLOGY 1160, 1160 (1998).

208. Sharon A. Brown & Deanna E. Grimes, *A Meta-Analysis of Nurse Practitioners and Nurse Midwives in Primary Care*, 44 NURSING RES. 332, 337 (1995). The comparison favored CNMs on all outcomes except for an increased likelihood of spontaneous perineal tears—a finding that is compatible with reduced rates of episiotomy (a second-degree incision). See *id.*

the United States and confirms the safety of home birth.²⁰⁹ Researchers reported a cesarean rate of 5.2% (after transfer to the hospital), lower rates of medical interventions than hospital births, and just 0.9% of babies requiring transfer to the hospital after birth, mostly for non-urgent conditions.²¹⁰ In addition, the dataset suggested notable health benefits resulting from midwife-led care—92% of babies were born full term, weighing an average of eight pounds at birth, and nearly 98% of infants were breastfed at the six-week postpartum visit.²¹¹ In 2009, a British Columbia-based study found that women who delivered at home with midwives had half as many serious perineal tears and approximately a third less postpartum bleeding than women who delivered in the hospital.²¹²

Two studies published in 2015 analyzed the safety of out-of-hospital births and found a lower risk of complications for women who delivered at home, although the studies came to different conclusions about the risks to babies.²¹³ Researchers at Oregon Health and Science University (OHSU) identified 1.2 more perinatal deaths per one thousand deliveries among women who had planned home births as compared with women who had planned hospital births.²¹⁴ A Canadian study, however, found no difference in perinatal deaths between planned home and hospital births.²¹⁵ The OHSU study reported twenty-four fewer cesareans per one hundred deliveries among women who had planned home births, while the Canadian study reported only two fewer cesareans—a difference likely associated with the fact that Canadian midwives continue to attend births of women who have transferred to hospitals, whereas women in the OHSU study would most likely have transferred directly to an obstetrician's care.²¹⁶

Critics may attack the safety record of midwifery care by arguing that selection bias diminishes the validity of the data on health outcomes. While it is true that midwife-attended births involve people who are on average healthier before and during pregnancy than the birthing population as a whole, that is to be expected—and is indeed unavoidable—because midwifery care is only appropriate for people experiencing low-risk pregnancies, which excludes people with certain chronic conditions.

209. See Melissa Cheyney, Marit Bovbjerg, Courtney Everson, Wendy Gordon, Darcy Hannibal & Saraswathi Vadam, *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 26 (2014).

210. *Id.* at 17.

211. *Id.* at 21–23.

212. Patricia A. Janssen, Lee Saxell, Lesley A. Page, Michael C. Klein, Robert M. Liston & Shoo K. Lee, *Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician*, 181 CANADIAN MED. ASS'N J. 377, 379 (2009).

213. Compare Jonathan M. Snowden, Ellen L. Tilden, Janice Snyder, Brian Quigley, Aaron B. Caughey & Yvonne W. Cheng, *Planned Out-of-Hospital Birth and Birth Outcomes*, 373 NEW ENG. J. MED. 2642, 2642 (2015) (finding that perinatal mortality is higher in out-of-hospital births than in-hospital births), with Eileen K. Hutton, Adriana Cappelletti, Angela H. Reitsma, Julia Simioni, Jordyn Horne, Caroline McGregor & Rashid J. Ahmed, *Outcomes Associated with Planned Place of Birth Among Women with Low-Risk Pregnancies*, 188 CANADIAN MED. ASS'N J. E80, E80 (2015) (finding no significant difference in infant mortality between out-of-hospital births and in-hospital births).

214. Snowden et al., *supra* note 213, at 2645.

215. See Hutton et al., *supra* note 213, at E80.

216. Henci Goer, *Dueling Statistics: Is Out-of-Hospital Birth Safe?*, 25 J. PERINATAL EDUC. 75, 75–76 (2016) (analyzing the differences between the Snowden and Hutton studies).

Midwives use risk assessment tools to determine whether a particular pregnant person is a good candidate for midwifery care, including whether planned community birth is advisable based on the person's risk profile.²¹⁷ With this understanding about the composition of midwifery consumers, the research on midwifery's safety record suggests two important conclusions: (1) giving birth attended by a midwife is a safe and reasonable option for people experiencing low-risk pregnancies, whether in a hospital-based or community setting; and (2) even when comparing only the experiences of similarly situated patients, people receiving midwifery care report less need for medical intervention during labor and delivery than physician-attended patients, a lower rate of cesarean delivery, and better health outcomes on a variety of measures.

C. *Economics of Midwifery*

Not only does midwifery care promote safe and healthy birth for pregnant people experiencing low-risk pregnancies, but its cheaper price tag also produces cost savings for various stakeholders, including hospitals, insurers, and patients. A 2017 study that differentiated hospital births by type of attendant supported increased use of CNMs to care for low-risk patients and decrease costs for the health care system.²¹⁸ Researchers reported savings from reduced use of certain labor and delivery interventions—such as cesarean delivery, vacuum-assisted delivery, epidural anesthesia, labor induction, and cervical ripening—and reduced length of hospital stays for patients who received midwife-led care in the hospital.²¹⁹ A 2014 study on the cost to the Medicaid program of payments for midwifery services provided to low-income women at a freestanding birth center in Washington, D.C., found an average 16% reduction in costs for every pregnant woman receiving care at the birth center, including prenatal care, delivery, and postpartum care.²²⁰ This amounted to \$11.6 million in savings for every ten thousand deliveries covered by Medicaid, prompting the study authors to suggest that policymakers should expand the role of midwives and birth centers in maternity care for low-risk Medicaid enrollees.²²¹

The State of Washington has taken an active interest in the cost-effectiveness of midwifery as part of its regulatory framework for licensed midwives. In 2007, the State of Washington Department of Health commissioned a study to determine whether the economic benefits of the state's Midwifery Licensure and Discipline Program exceeded the cost of subsidizing the program.²²² The study, using a conservative methodology to

217. See, e.g., VA. BD. OF MED., DISCLOSURES BY LICENSED MIDWIVES FOR HIGH-RISK PREGNANCY CONDITIONS, GUIDANCE DOCUMENT 85-10, at 1 (rev. 2015), <http://www.dhp.virginia.gov/medicine/guidelines/85-10.pdf> [<https://perma.cc/MYH4-Y7VL>].

218. Molly R. Altman, Sean M. Murphy, Cynthia E. Fitzgerald, H. Frank Andersen & Kenn B. Daratha, *The Cost of Nurse-Midwifery Care: Use of Interventions, Resources, and Associated Costs in the Hospital Setting*, 27 WOMEN'S HEALTH ISSUES 434, 438–40 (2017).

219. See *id.* Maternal and neonatal outcomes were comparable across the groups in the study. See *id.*

220. Embry Howell, Ashley Palmer, Sarah Benatar & Bowen Garrett, *Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center*, 4 MEDICARE & MEDICAID RES. REV., no. 3, 2014, at E1, E7.

221. See *id.* at E9–10.

222. HEALTH MGMT. ASSOCS., MIDWIFERY LICENSURE AND DISCIPLINE PROGRAM IN WASHINGTON STATE: ECONOMIC COSTS AND BENEFITS 1 (2007).

analyze cost estimates, estimated savings to the health care system associated with midwifery care to be \$2.7 million, which was nearly ten times the cost of the program and thus was deemed to be a cost-effective use of state funds.²²³ The authors noted that they excluded potential cost savings from avoided medical intervention in community births because it was impossible to quantify cost savings accurately.²²⁴ Instead, they identified evidence that the one-on-one labor support provided by midwives is associated with lower cesarean rates and noted a range of cost savings estimates for potentially avoided cesareans, “demonstrat[ing] that even the most modest favorable effect on lowering the [cesarean] rates associated with licensed midwives leads to substantial savings to the health care system, as well as lower medical risk and cost to the family.”²²⁵

A 2014 study published in *The Lancet*—one of the most well-respected general medical journals in the world—conducted a widespread review of existing research on midwifery and identified seventy-two effective maternity care practices that fall within the scope of midwifery.²²⁶ The researchers concluded that in high-income settings, such as the United States, midwife-led care is “a more cost-effective option than medically-led care,” finding support in the data for multidisciplinary collaborations between midwives and medical professionals to care for pregnant people and infants who develop complications.²²⁷

In addition to direct cost savings to the health care system, research suggests that the promotion of midwifery may also realize cost savings in terms of malpractice liability. A 2007 study that surveyed ACNM members about their experiences with litigation in their midwifery practices found that approximately 25% of respondents had been named in a lawsuit at least once during their careers in midwifery.²²⁸ In contrast, ACOG’s 2003 Survey of Professional Liability reported that 76.3% of ACOG members have been involved in a lawsuit at least once during their professional careers.²²⁹ While the ACOG study authors noted certain limitations of the ACNM study, including a relatively low response rate, the fact that midwives are significantly less likely than physicians to be sued by a patient suggests that midwifery presents additional cost savings in the form of avoided malpractice liability exposure.²³⁰

223. *Id.*

224. *Id.*

225. *Id.* at 1–2.

226. MARY J. RENFREW, CAROLINE S. E. HOMER, SOO DOWNE, ALISON MCFADDEN, NATALIE MUIR, THOMSON PRENTICE & PETRA TEN HOOPE-BENDER, *THE LANCET*, MIDWIFERY: AN EXECUTIVE SUMMARY FOR THE LANCET’S SERIES 4–5 (2014), http://www.thelancet.com/pb/assets/raw/Lancet/stories/series/midwifery/midwifery_exec_summ.pdf [<https://perma.cc/U5N3-54MW>].

227. *Id.* at 5.

228. William F. McCool, Mamie Guidera, Sarah Hakala & Erica J. Delaney, *The Role of Litigation in Midwifery Practice in the United States: Results from a Nationwide Survey of Certified Nurse-Midwives/Certified Midwives*, 52 J. MIDWIFERY & WOMEN’S HEALTH 458, 460 (2007).

229. *Id.* at 458.

230. *See id.* at 461–63 (noting the need for additional research on the role of malpractice liability in midwifery practice). Authors of the study noted it was possible that the survey captured an overestimate of litigation involvement by midwives if survey recipients were more likely to respond when they had in fact been sued because the survey gave them an opportunity to share their experiences. On the other hand, it is possible the study reflected an undercount if concerns about confidentiality and reputational harm deterred midwives from disclosing their history of litigation. *Id.* at 461.

D. *Benefits of Promoting & Integrating Midwives*

Given the complexities of the current maternity care system, there are various ways that increasing the role of midwives stands to improve both health outcomes and birth experiences system-wide. First, while an enhanced midwifery workforce would not provide intrapartum care for people with serious health conditions who are at higher risk of adverse outcomes, by caring for a greater proportion of low-risk patients, midwives would ease the burden on physicians and enable obstetricians and other high-risk specialists to spend more time—both prenatally and during labor and delivery—caring for patients at higher risk of developing complications. Given that obstetricians are trained surgeons, greater alignment of patient and provider by risk type would be a more rational way to allocate maternity care resources across the patient population. A model of true interprofessional collaboration between midwives and physicians, in which maternity care teams are collectively accountable for providing appropriate care, could avoid a zero-sum situation in which physicians unfairly bear more risk and the greater cost of malpractice exposure because their medical training means they care for more patients with adverse health outcomes than their midwife colleagues. Under a collaborative model that better aligns provider expertise with patient risk profile, all patients will be positioned to receive care that best meets their needs.

Second, greater availability of and reliance on midwives means that a larger proportion of people experiencing low-risk pregnancies will have access to low-intervention, physiologic birth, rather than being compelled to give birth in high-intervention settings because there are no alternatives. For pregnant people who want to give birth with minimal intervention, the benefits of improved health outcomes will accrue on an individual level, while the benefits of reduced cost will accrue across the maternity care system as a whole.²³¹

Third, in a truly integrated maternity care system, midwifery care does not have to be all or nothing. Pregnant people receiving midwifery care who ultimately need medical care by a physician as pregnancy (or labor) progresses—referred to as “risking out” of midwifery care²³²—will nevertheless benefit from the more holistic version of prenatal care provided by midwives until the point of risking out, especially pregnant people whose race, class, age, sexuality, gender identity, or disability present psychosocial needs that midwives are particularly well suited to address in the course of providing prenatal care. Rather than shifting between two different systems, as is currently the case, the birthing person can benefit from continuing to have the midwife as part of the team, providing other forms of support.

Finally, a more visible role for midwives in mainstream maternity care can produce positive systematic changes in the organization, financing, and culture of childbirth. For example, as more pregnant people experience the health benefits of longer prenatal appointments with more holistic education, counseling, and care by their midwives, obstetrics practices may find consumer demand requires them to alter how they structure

231. See *supra* Section II.

232. Kristen, *How to Decide if Home Birth Is Right for You*, <http://www.naturalbirthandbabycare.com/homebirth/> [https://perma.cc/LM9K-DNU2] (last visited Feb. 1, 2021) (explaining that “risking out” refers to a decision by the midwife and pregnant person that it would be safer to deliver in the hospital due to a health indication that has arisen during pregnancy or labor).

prenatal care and compel insurers to change how they reimburse for the provision of prenatal care.²³³ While some physicians would undoubtedly resent and may resist such pressure to change, other providers who feel squeezed by hospital administrators and reimbursement policies may find additional freedom to practice patient-centered, evidence-based medicine as a result of cultural changes brought about by greater integration of midwives throughout the maternity care system.²³⁴ In this way, the growth of midwifery would benefit all pregnant people—even those giving birth with physicians.

III. BARRIERS TO INTEGRATION OF MIDWIFERY

Although the benefits of midwifery are well established, many pregnant people in the United States face significant barriers to accessing midwifery care or simply lack any option for midwife-attended birth. The decentralized nature of professional regulation means that there is significant variation among the states in how midwives are recognized, regulated, and integrated into mainstream maternity care. In many jurisdictions, recognition of direct-entry midwifery was the result of concerted organizing, years-long campaigning, and dogged persistence in the legislative and regulatory arenas.

Part III.A briefly examines the historical marginalization of midwives in early periods of American history to contextualize the roots of current restrictions on midwifery practice. Part III.B considers the modern-day marginalization of midwives through both legislative exclusion and burdensome regulation. Finally, in order to illustrate the negative implications of such marginalization, Part III.C considers Pennsylvania as a case study of legislative exclusion and regulatory burden, highlighting the issues where midwives tend to face the most resistance and how such legal restrictions impede greater access to midwifery care.

A. *Historical Marginalization of Midwives*

The majority of births in colonial America were attended by midwives, with physician involvement only in complicated situations that called for the use of instruments.²³⁵ Midwives and physicians experienced peaceful coexistence in a “system of cooperation” and “professional courtesy” until the early nineteenth century.²³⁶ This

233. There is evidence that hospitals with more midwife-attended births use fewer interventions, though it is unclear whether the difference results from consumer demand, organic changes in the culture of the clinical setting, or a combination of factors. See, e.g., Laura Attanasio & Katy B. Kozhimannil, *Relationship Between Hospital-Level Percentage of Midwife-Attended Births and Obstetric Procedure Utilization*, 63 J. MIDWIFERY & WOMEN'S HEALTH 14, 19 (2017) (finding women who delivered at hospitals with more midwife-attended births had lower-than-average cesarean and episiotomy rates).

234. See THERESA MORRIS, CUT IT OUT: THE C-SECTION EPIDEMIC IN AMERICA 22–26 (2013) (discussing institutional constraints on physicians as a factor contributing to the high cesarean rate in the United States).

235. See Scholten, *supra* note 65, at 427, 434 (“[C]hildbirth was an event shared by the female community; and delivery was supervised by a midwife.”).

236. See Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 64 (2004) (citing LAUREL THATCHER ULRICH, A MIDWIFE'S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER DIARY, 1785–1812, at 61 (1991)).

changed when physicians began to professionalize.²³⁷ Seeking a more stable and lucrative patient base, physicians started cultivating demand for a “higher standard of obstetrics.”²³⁸

Indeed, the transition from midwife-attended home birth to physician-attended hospital birth was not simply an organic development that reflected consumer demand. Rather, physicians actively led the campaign against midwives, generating propaganda that characterized midwives—many of whom were immigrants—as dirty, illiterate, ignorant, and irresponsible.²³⁹ White physicians invoked racial stereotypes to discourage White women from hiring African American “granny” midwives,²⁴⁰ referring to midwifery as a “relic of barbarism” and calling midwives “filthy and ignorant and not far removed from the jungles of Africa.”²⁴¹ The campaign against midwives drew most middle- and upper-class women to physician-attended births in the hospital, which were portrayed as clean, scientific, and the epitome of responsibility in health care, while immigrant and poor families continued to birth with midwives in their communities.²⁴²

In addition to attacking midwifery in the court of public opinion, physicians also sought the criminal prosecution of midwives in legal actions that were generally brought in the wake of a death, usually initiated by physicians serving on medical boards rather than the clients or their families.²⁴³ In her analysis of judicial opinions in midwifery cases, legal scholar Stacey Tovino noted that courts refused to acknowledge the skills and expertise of the defendant midwives, as well as their positive health outcomes, “suggest[ing] that the women midwives’ experiential knowledge was both subordinate

237. See STARR, *supra* note 66, at 49–51.

238. Suarez, *supra* note 67, at 327 (quoting Frances E. Kobrin, *The American Midwife Controversy: A Crisis of Professionalization*, 40 BULL. HIST. MED. 350, 359 (1966), reprinted in WOMEN AND HEALTH IN AMERICA 318, 322 (Judith Waltz Leavitt ed., 1984)); see also JEAN DONNISON, MIDWIVES AND MEDICAL MEN: A HISTORY OF THE STRUGGLE FOR THE CONTROL OF CHILDBIRTH 44–45 (1988); Kukura, *Contested Care*, *supra* note 35, at 251 (noting that unlike midwives, most newly trained nineteenth-century doctors lacked clinical experience with childbirth due to concerns about modesty that prevented trainees from observing women in labor). By the early twentieth century, the need for more training opportunities was another reason physicians advocated for the elimination of midwives. See Charles Edward Ziegler, *The Elimination of the Midwife*, 60 JAMA 32, 33 (1913) (“It is, at present, impossible to secure cases sufficient for the proper training of physicians in obstetrics, since 75 [%] of the material otherwise available for clinical purposes is utilized in providing a livelihood for midwives.”).

239. See Neal Devitt, *The Statistical Case for Elimination of the Midwife: Fact Versus Prejudice, 1890–1935 (Part 1)*, 4 WOMEN & HEALTH 81, 89 (1979).

240. See MARGARET CHARLES SMITH & LINDA JANET HOLMES, LISTEN TO ME GOOD: THE LIFE STORY OF AN ALABAMA MIDWIFE 21–23 (1996). Prior to the anti-midwife propaganda campaign, respect for Black “granny” midwives was generally widespread.

241. Devitt, *supra* note 239, at 89 (first quoting Joseph B. DeLee, *Progress Towards Ideal Obstetrics*, in AM. ASS’N FOR THE STUDY & PREVENTION OF INFANT MORTALITY, TRANSACTIONS OF THE SIXTH ANNUAL MEETING: PHILADELPHIA, NOVEMBER 10–12, 1915, at 114 (1916); and then quoting Felix J. Underwood, *The Development of Midwifery in Mississippi*, 19 S. MED. J. 683, 683 (1926)).

242. See Robbie Davis-Floyd, *ACNM and MANA: Divergent Histories and Convergent Trends*, in MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 29, 32–34 (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006).

243. See, e.g., Tovino, *supra* note 236, at 82–87 (discussing Finnish midwife Hanna Porn’s ten separate criminal prosecutions for attending births in Massachusetts).

to the male physician's new scientific knowledge and rejected as a means of establishing professional and legal standing."²⁴⁴

The establishment of nurse-midwifery in the 1920s and subsequent founding of the ACNM in 1969 also illustrate the complex and strategic forces that diminished the stature of American midwifery.²⁴⁵ Although nurse-midwifery filled important gaps in access to maternity care for poor, rural women starting in the twentieth century, it also represented a more palatable alternative to the independent midwives who had resisted medical and state oversight. Nurse-midwives generally operated under the supervision of physicians, granting the medical profession ultimate authority over where and how midwives practiced.²⁴⁶ Because nurses are widely perceived as a helping profession—and largely female—nurse-midwifery was understood to be more controllable and therefore less threatening than direct-entry midwives, who remained the target of repression and ire by the medical profession.²⁴⁷ Even today, nurse-midwives occupy shifting terrain, sometimes aligned with CPMs and other independent midwives on political and legal issues facing the midwifery profession as a whole, while at other times seeking to distance themselves from their direct-entry colleagues.²⁴⁸

B. Modern Marginalization of Midwives

Although much has changed since the first conflicts over who was best suited to attend women in childbirth arose, interprofessional hostility between physicians and midwives continues today. Turf battles and the continued struggle over the soul of American childbirth have taken various forms in the twenty-first century, including high-profile prosecutions of midwives for practicing medicine or nursing without a license,²⁴⁹ the targeting of midwife-run birth centers,²⁵⁰ and the filing of complaints with

244. *Id.* at 106.

245. See Dawley, *supra* note 72, at 88–89; see also *The ACNM as an Organization*, AM. COLL. OF NURSE-MIDWIVES, <http://www.midwife.org/The-ACNM-as-an-Organization> [https://perma.cc/GF98-4HKF] (last visited Feb. 1, 2021).

246. See Dawley, *supra* note 72, at 88.

247. See BARBARA EHRENREICH & DEIRDRE ENGLISH, *WITCHES, MIDWIVES & NURSES: A HISTORY OF WOMEN HEALERS* 48–53 (2d ed. 2010) (ebook).

248. See Christine Barbara Johnson, *Creating a Way Out of No Way: Midwifery in Massachusetts*, in *MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE*, *supra* note 242, at 375, 398–99 (discussing examples of collaboration and alliance between CNMs and CPMs).

249. See Noah Berlatsky, *When Midwives Are Considered Criminals*, VICE (Sep. 13, 2015, 9:05 AM), http://www.vice.com/en_us/article/a3wvmz/when-midwives-are-considered-criminals [https://perma.cc/7NMG-Y28D]; Gwen Chamberlain, *Second Woman Charged in Yates County Midwife Case*, CHRONICLE-EXPRESS (Mar. 9, 2020, 6:41 PM), <http://www.chronicle-express.com/news/20200309/second-woman-charged-in-yates-county-midwife-case> [https://perma.cc/2YBA-ANJP]; Adam Liptak, *Prosecution of Midwife Casts Light on Home Births*, N.Y. TIMES (Apr. 3, 2006), <http://www.nytimes.com/2006/04/03/us/03midwife.html> [https://perma.cc/8V95-AMNR]; Martha Mendoza, *Prosecutions Thin Ranks of Midwives*, WASH. POST (Dec. 22, 2002), <http://www.washingtonpost.com/archive/politics/2002/12/22/prosecutions-thin-ranks-of-midwives/87f7f675-7c32-4a88-853a-0ee4cc490748/> [https://perma.cc/7LXL-3GCL].

250. See Joe Rojas-Burke, *Doctor-Midwife Tensions Run Deep*, OREGONIAN (Aug. 4, 2010), https://www.oregonlive.com/health/index.ssf/2010/08/doctor-midwife_tensions_run_de.html [https://perma.cc/A34S-HLBC].

licensing boards to tarnish midwives' professional reputations.²⁵¹ The most far-reaching forms of modern-day marginalization of midwives come either in the form of opposition to licensure (or other forms of liberalized practice) in the legislative arena²⁵² or restrictive regulations imposed by state authorities when implementing a licensing regime.²⁵³

1. Legislative Hostility

All fifty states recognize CNMs and provide a regulatory framework for their practice of midwifery.²⁵⁴ This has enabled CNMs to attend births in different settings and made it easier for patients to obtain insurance coverage for their midwifery care.²⁵⁵ However, legislative treatment of direct-entry midwives continues to be a patchwork of recognition, promotion, or hostility.

In 1970, there were no laws licensing direct-entry midwives in the United States.²⁵⁶ A decade later, four states had legally recognized direct-entry midwives; these early adopters were South Carolina, Arizona, New Mexico, and Delaware.²⁵⁷ By the time NARM introduced the CPM credential in 1994, there were fourteen states that licensed direct-entry midwives, and by 2010, that number had risen to twenty-six states—including Missouri, which in 2007 authorized CPM practice by statute without adopting a licensure framework.²⁵⁸ In 2010, the International Confederation of Midwives adopted a standardized minimum level of training for all midwives, including in the United States,²⁵⁹ which was ultimately embraced by major U.S. midwifery organizations through the formation of US Midwifery Education, Regulation, and Association (US MERA).²⁶⁰ The educational requirements for CPMs continue to be a contested issue in legislative negotiations, and post-US MERA legislative efforts have produced both restrictive regulations²⁶¹ and laws that advocates consider to be legislative wins.²⁶²

251. *See id.*

252. *See infra* Part III.B.1.

253. *See infra* Part III.B.2.

254. *The Credential CNM and CM*, *supra* note 182.

255. *See CNM, CPM, CM, Doula: Understanding Midwifery Roles, Credentials, and Scope of Practice*, MIDWIFESCHOOLING.COM, <http://www.midwifeschooling.com/midwifery-roles-and-credentials/> [https://perma.cc/YN2D-EQ5G] (last visited Feb. 1, 2021).

256. *See CPMs Legal Status by State*, *supra* note 179.

257. *Id.*

258. *Id.*

259. INT'L CONFEDERATION OF MIDWIVES, GLOBAL STANDARDS FOR MIDWIFERY EDUCATION (2010) (amended 2013).

260. US MERA, AM. COLL. OF NURSE-MIDWIVES, <http://www.midwife.org/US-MERA> [https://perma.cc/VQ9Q-4WPE] (last updated July 2015).

261. *See, e.g.*, H.D. 9, 2015 Leg., 435th Sess. (Md. 2015) (reflecting an example of licensure legislation that extensively details scope of practice and other aspects of midwifery better left for the regulatory process).

262. *See, e.g.*, ALA. CODE 1975 §§ 34-19-12 to -21 (West 2017) (providing an example of a decriminalization bill for Alabama direct-entry midwives); H.R. 2184, 116th Cong., 1st Sess. (Haw. 2018) (providing exemptions from licensure for indigenous and traditional midwives); S. 136, 116th Cong., 1st Sess. (S.D. 2017) (providing an example of a direct-entry midwife licensure bill that creates an independent board of midwifery for regulatory oversight).

Thirty-six states currently license, or otherwise authorize, midwifery practice by CPMs.²⁶³

The legislative battles in many of the licensed states have been expensive, multiyear, highly contested endeavors that required politicians to engage with scientific research on the health and safety of home birth, included personal attacks waged against community midwives, and drew significant consumer support—often in the form of legislative hearings packed with babies and small children appearing with their parents in support of their midwives.²⁶⁴ In their study of the emergence of the alternative birth movement, sociolegal scholars Katherine Beckett and Bruce Hoffman demonstrated the significant role that the medical profession's assertion of its authority over childbirth played in galvanizing organized forms of birth activism, including advocacy on behalf of midwifery licensure.²⁶⁵ As activists developed more power as a social movement, the ongoing cultural struggle over who serves as primary caregivers for pregnant people in the United States shifted to the legislative arena.²⁶⁶ Unlike a court proceeding, which focused on the particular midwife facing scrutiny and the facts of the individual case before the court, legislative airing of arguments for and against midwifery enabled midwifery advocates to mobilize additional tools, including scientific research studies, personal narratives, and the presence of healthy, happy babies, who had been born at home with midwives, babbling away in the legislative chamber.²⁶⁷

Active licensure campaigns are underway in four states—Illinois, Iowa, Massachusetts, and Georgia—and are supported by consumer organizing and lobbying by professional associations in those states.²⁶⁸ It is likely that some form of licensure for direct-entry midwives will eventually be achieved in all fifty states.²⁶⁹ However, statutory recognition of midwives through licensure is not enough to dismantle the anti-midwifery hostility baked into state law. Once the licensing bill becomes law, attention shifts to the regulatory arena for drafting of specific rules and ongoing oversight of midwives within the state.

263. *CPMs Legal Status by State*, *supra* note 179. Because Medicaid providers must be licensed, lack of licensure exacerbates the midwifery access gap for pregnant people who rely on Medicaid to cover the costs of childbirth-related care. NAT'L ASS'N OF CERTIFIED PROF'L MIDWIVES, CPMs: MIDWIFERY LANDSCAPE AND FUTURE DIRECTIONS 2 (2017), <http://www.nacpm.org/wp-content/uploads/2017/10/2A-NACPM-Vision-and-National-Landscape-for-CPMs.pdf> [<https://perma.cc/32X9-Y5L4>]. Midwifery proponents are currently engaged in legislative advocacy to make all CPMs eligible for Medicaid reimbursement, but for CPMs in non-licensure states, achieving legal recognition under state law is an important first step. *See id.*

264. *See* Beckett & Hoffman, *supra* note 76, at 130, 149.

265. *Id.* at 125–27.

266. *See id.* at 126.

267. *See id.* at 129, 149, 160–61.

268. *CPMs Legal Status by State*, *supra* note 179.

269. In addition to the lack of legal recognition for direct-entry midwives, ten states do not currently license freestanding birth centers, which precludes Medicaid reimbursement for birth center facility fees and further impedes access to midwifery care. *See Birth Centers Regulations*, AM. ASS'N OF BIRTH CENTERS, http://www.birthcenters.org/page/bc_regulations [<https://perma.cc/SH8U-M7CJ>] (last visited Feb. 1, 2021); *see also* 42 U.S.C. § 1396d(l)(3)(A)–(C) (2018).

2. Regulatory Hostility

Many states that recognize and license direct-entry midwives have nevertheless adopted restrictive regulations that limit where and how midwives can practice. For example, some states require that midwives enter into a collaborative agreement with a supervising physician, thus imposing a relationship between the midwife and physician,²⁷⁰ rather than promoting a system where professional relationships are built on trust, mutual respect, and a desire to collaborate to protect and promote pregnant people's health. This sets midwifery apart from other health care professions, such as medicine and nursing, which create their own practice guidelines in a system of self-regulation.²⁷¹ Although justified as protecting public health, there is no evidence that physician collaborative agreements serve a valid public health goal where direct-entry midwives are already licensed, having satisfied the education and credentialing requirements of the state. In practice, such supervision requirements function as anticompetitive restraints that inhibit the growth of midwifery—especially in areas where there are no physicians willing to enter into a collaborative agreement with midwives—and protect physicians from competition at the expense of the health and well-being of pregnant people and infants.

Likewise, other state regulations impose practical restraints on the ability of direct-entry midwives to practice and impede access to midwifery care for people experiencing low-risk pregnancies. These regulatory barriers include limitations on prescriptive authority, which prevent midwives from accessing certain needed medications like drugs to stop a postpartum hemorrhage and explicit restrictions on which clients midwives can serve,²⁷² excluding people carrying twins, people whose babies are lying in a breech position, or people who want to deliver vaginally after a prior cesarean.²⁷³

Some states require midwives to carry malpractice insurance without considering the differences in malpractice risk, practice volume, income, and institutional affiliation between physicians and midwives that make malpractice premiums cost prohibitive for low-volume, independent midwifery practices in the absence of an accommodation or subsidy by the state.²⁷⁴ In certain states, direct-entry midwives are required by law to

270. See Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, Emma Butt, Y. Tony Yang & Holly Powell Kennedy, *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, PLOS ONE, Feb. 21, 2018, at 1 *passim*, <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0192523&type=printable> [<https://perma.cc/H9QQ-ZLVN>] [hereinafter Vedam et al., *Mapping Integration*] (detailing midwifery practice and interprofessional collaboration in all fifty states); TASK FORCE ON COLLABORATIVE PRACTICE, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *COLLABORATION IN PRACTICE: IMPLEMENTING TEAM-BASED CARE* 17 (2016).

271. See generally William D. White, *Professional Self-Regulation in Medicine*, 16 VIRTUAL MENTOR 275 (2014), <http://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/hlaw1-1404.pdf> [<https://perma.cc/GRC8-H946>] (discussing how professional regulation increases a patient's trust in their physician).

272. See, e.g., Vedam et al., *Mapping Integration*, *supra* note 270, at 5–6.

273. See Rebecca Fotsch, *Regulating Certified Professional Midwives in State Legislatures*, 8 J. NURSING REG. 47, 48 (2017).

274. See, e.g., FLA. ADMIN. CODE ANN. r. 64B24-7.013 (2020) (requiring midwifery license applicants to provide proof of professional liability coverage).

consult with physicians for particular conditions—an infringement on their professional autonomy as fully trained midwives—and some states require additional steps beyond obtaining the CPM credential in order to qualify for a state license.²⁷⁵ Another regulatory barrier that prevents some direct-entry midwives from practicing to the full extent of their training is scope of practice restrictions that limit care to the childbearing year, excluding well-woman care, such as family planning counseling and pap smears.²⁷⁶

Nurse-midwives may find their ability to practice restricted by regulatory limitations on their prescriptive authority, including the requirement that they enter into separate collaborative agreements with physicians in order to prescribe certain drugs.²⁷⁷ CNMs may also face restrictions on their ability to obtain hospital privileges in the state, may be required to consult with physicians in order to treat patients with certain conditions, and may have to fulfill additional requirements beyond the CNM credential in order to be eligible to receive a state license.²⁷⁸

In 2018, a multidisciplinary team of researchers released the results of a landmark study about the integration of midwives into local and regional health systems across the United States, known as the Access and Integration Maternity Care Mapping (AIMM) study.²⁷⁹ The researchers created the Midwifery Integration Scoring System to identify and weigh the impact of various state regulatory provisions governing practice by both nurse-midwives and direct-entry midwives in all fifty states.²⁸⁰ Higher scores indicate greater integration of midwives into the health system across all settings—in hospitals, birth centers, and at home.²⁸¹ Strikingly, the state that earned the highest integration score—Washington—scored only sixty-one out of one hundred, which the study authors noted “represent[s] less than two thirds . . . of condition requirements for a fully integrated system for care.”²⁸² Taken as a whole, the AIMM study tells a story about the strong negative impact of restrictive state regulation on the ability of midwives to practice to the full extent of their training and credentials.

In addition to specific state regulations, the decision of where midwifery oversight is located within the state regulatory structure is a critical threshold question that shapes how much power midwives have to self-regulate, to provide care to pregnant people of all racial and socioeconomic backgrounds, and to earn a sustainable living. Licensing

275. See Vedam et al., *Mapping Integration*, *supra* note 270, at 15 tbl.S1 (containing Midwifery Integration Scoring System indicators, including whether a state maintains additional requirements for CPMs seeking licensure beyond holding the credential); see, e.g., *Midwife Licensing Requirements*, WASH. ST. DEP’T HEALTH, <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/Midwife/LicenseRequirements> [https://perma.cc/JNU4-RWAZ] (last visited Feb. 1, 2021) (noting that there is a separate Washington state licensing exam and that there are other requirements for credentialed midwives to obtain a state license).

276. See Vedam et al., *Mapping Integration*, *supra* note 270, at 15 tbl.S1 (detailing a Midwifery Integration Scoring System indicator that measures state restrictions regarding well-woman care by CPMs).

277. See *id.* at 6.

278. See *id.* at 5–6.

279. *Id.* at 6.

280. *Id.* at 1.

281. *Id.*

282. *Id.* at 1, 11. Only twelve states earned a score of fifty or above, while twelve earned a score of twenty-five or below. *Id.* at 8 fig.1. North Carolina ranked lowest with a score of seventeen out of one hundred. *Id.*

boards are state agencies with the power to promulgate rules and regulations regarding midwifery practice, as well as provide ongoing oversight of midwifery licensure, including professional discipline.²⁸³ The United States maintains a model of self-regulated health care professions—a board composed of experts drawn from the profession and other interested stakeholders is essential to the proper functioning of this regulatory structure.²⁸⁴ In some jurisdictions, however, direct-entry midwives are regulated by the board of medicine or the board of nursing—composed of a majority of members from those professions—despite the fact that physicians and nurses are not experts in autonomous midwifery and are not well suited to regulate and oversee the practice of direct-entry midwifery.²⁸⁵ When physicians or nurses responsible for midwifery oversight use their economic and political advantage to marginalize their perceived economic competitors,²⁸⁶ they are hijacking the regulatory process to advance their own professional interests, which constitutes an improper leveraging of state power at the expense of birthing people and their families.²⁸⁷

C. Case Study: Pennsylvania

Midwifery-restrictive “regulatory barriers” is a broad concept, and different types of rules can have different impacts depending on geographic, cultural, and other considerations. This Part takes a deeper look at state regulations that impede the midwifery profession by examining midwifery in the Commonwealth of Pennsylvania—a state with a mix of urban, suburban, and rural populations that is one of the top ten home birth states, due in large part to its Amish and Mennonite populations.²⁸⁸

While this case study illustrates the typical impact of several common midwifery regulations, it also highlights certain Pennsylvania-specific concerns. The *sui generis*

283. See *State Licensing and Certification Agencies*, U.S. DEP’T OF HEALTH & HUM. SERVS., NAT’L PRAC. DATA BANK, <http://www.npdb.hrsa.gov/orgs/stateBoard.jsp> [<https://perma.cc/GH37-5L7L>] (last visited Feb. 1, 2021).

284. See White, *supra* note 271 (providing an overview of professional self-regulation in health care).

285. See, e.g., *Licensed Midwives*, MED. BD. OF CAL., <http://www.mbc.ca.gov/Licensees/Midwives/> [<https://perma.cc/6NSZ-R7QR>] (last visited Feb. 1, 2021).

286. For example, in 2005, the American Medical Association House of Delegates adopted a resolution to “embark on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising their full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by boards of nursing or other entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.” See Steff Hedenkamp, *Statement of the Big Push for Midwives Campaign on the AMA Scope of Practice Partnership*, BIG PUSH FOR MIDWIVES (July 15, 2013, 9:30 AM), <http://www.pushformidwives.org/tags/scopeofpracticepartnership> [<https://perma.cc/5M7T-X28X>]. This directive reflects a concerted effort by physicians to assert medical control over other licensed health care professionals and led several state medical boards to target direct-entry midwives in states without licensure. See *id.*

287. Cf. Martha Albertson Fineman, *The Vulnerable Subject and the Responsive State*, 60 EMORY L.J. 251, 255–56 (2010) (discussing the vulnerability of societal institutions to “a variety of internal and external corruptions and disruptions” which necessitates active monitoring by the state in a manner that is “transparent and inclusive”).

288. See Chris Togneri, *Amish Population Shrinks in Pennsylvania*, TRIB LIVE (June 5, 2013, 11:35 PM), <http://archive.triblive.com/news/amish-population-shrinks-in-pennsylvania/> [<https://perma.cc/R79U-Y4J8>] (reporting Pennsylvania’s Amish population to be 63,785, second only to Ohio with 63,990 Amish residents).

nature of those concerns reflects the complexity of state-level midwifery regulation—often the product of specific local conditions and external factors that shape whether and how a state chooses to regulate midwives—and underscores the need for legal intervention at the federal level in addition to liberalization of midwifery regulation among the states.²⁸⁹

The majority of midwives practicing in Pennsylvania are CNMs; they are the only type of midwife licensed and fully recognized under Pennsylvania law.²⁹⁰ Although CNMs are fully trained experts in managing the care of women experiencing low-risk pregnancies and can practice in hospitals, freestanding birth centers, and at home, Pennsylvania requires that they enter into a collaborative agreement with a supervising physician.²⁹¹ In addition to sending an inaccurate signal that midwives are not capable of providing this care, the collaborative agreement requirement limits some CNMs from maintaining birth center or home birth practices due to their inability to find a willing physician—especially those who live in areas where local physicians are hostile to out-of-hospital births.²⁹² CNMs are also restricted in their ability to write prescriptions and must enter into a separate collaborative agreement with a supervising physician that spells out exactly which categories of drugs the midwife may prescribe or dispense.²⁹³ Due to these additional requirements, CNMs are not practicing to the full extent of their training.

Pennsylvania also has a number of CPMs and other direct-entry midwives who attend home births. Direct-entry midwives were recognized in a 1929 statute that prohibited the practice of midwifery without a certificate from the State Board of Medical Education and Licensure—the predecessor of the current State Board of Medicine (SBOM).²⁹⁴ The statute gave the medical board the authority to issue and revoke midwifery certificates and empowered the Secretary of Health to appoint a physician review board to supervise midwives and enforce the statute, which includes penalties for unlicensed midwives practicing midwifery within the Commonwealth.²⁹⁵ The board, however, never issued any modern regulations providing for such licensure, which has left direct-entry midwives practicing in a legal grey area even as Pennsylvania law has

289. For example, the Midwives and Mothers in Action campaign seeks an amendment to the Social Security Act to provide Medicaid coverage for CPMs and CMs. See *Midwives and Mothers in Action (MAMA) Campaign*, NAT'L ASS'N OF CERTIFIED PROF. MIDWIVES, <http://nacpm.org/mamacampaign/> [<https://perma.cc/8VNU-S4LE>] (last visited Feb. 1, 2021).

290. See CARA KINZELMAN & JESSE BUSHMAN, AM. COLL. OF NURSE-MIDWIVES, UNDERSTANDING YOUR PRACTICE ENVIRONMENT: MAKING AN INFORMED DECISION ABOUT WHERE TO WORK 35–37 (2015), <http://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005198/StateEnvironments5-11-15v3.pdf> [<https://perma.cc/V25X-X4HQ>]. As of 2015, there are 429 CNMs practicing in Pennsylvania, and they attend approximately 11% of births in the Commonwealth each year. *Id.* at 3, 15.

291. See 49 PA. CODE § 18.5 (2020).

292. See *id.*

293. See *id.* § 18.6a.

294. Midwife Regulation Law, 1929 Pa. Laws 160 (“[I]t 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 . . .”).

295. *Id.*

evolved to recognize nurse-midwives.²⁹⁶ Although there have been relatively few enforcement actions, midwives practice knowing that they could be subject to criminal prosecution or other discipline in the event of a bad outcome.

Given this uncertainty—and the extent to which it discourages new direct-entry midwives from practicing in Pennsylvania—some CPMs have pursued a new licensure law.²⁹⁷ Until now, all such efforts have failed because the Pennsylvania Medical Society and its allies in the state legislature have insisted on a series of restrictive regulations in exchange for granting licenses, including physician oversight in the form of a collaborative agreement, required malpractice insurance coverage, and regulation under the SBOM.²⁹⁸ First, CPMs are wary of enshrining a collaborative agreement requirement in law. Midwives perceive the requirement as an encroachment on their autonomy, independence, and expertise.²⁹⁹ CPMs have also observed that, in some states with this requirement, physician hostility to midwives means that it is difficult or impossible for a CPM to find a physician willing to enter into this agreement.³⁰⁰ Thus, even with licensure, midwifery practice is effectively stopped or midwives continue to practice without the agreement, a result that is in violation of the law and makes the regulatory framework meaningless in terms of providing oversight and promoting public health and safety.³⁰¹ The potential difficulty of securing a supervising physician is a particular concern in Pennsylvania, which is geographically large and has sizable rural areas without nearby hospitals where communities rely on direct-entry midwives for essential care.³⁰²

Second, CPMs object to the malpractice insurance requirement because it fails to account for key differences between the practice of medicine and the practice of

296. See, e.g., *Goslin v. State Bd. of Med.*, 937 A.2d 531, 533–34 (Pa. Commw. Ct. 2007), *rev'd*, 949 A.2d 372 (Pa. Commw. Ct. 2008).

297. Conversation with Christy Santoro, a Philadelphia-based CPM (May 13, 2019).

298. *Id.* Midwifery advocates have not renewed a major push for licensure in the last several years. See Jo Ciavaglia, *Maternity Gap: NJ Licenses Non-Nurse Midwives, Pennsylvania Doesn't*, INTELLIGENCER (May 26, 2019, 9:00 AM), <http://www.theintell.com/news/20190526/maternity-gap-nj-licenses-non-nurse-midwives-pennsylvania-doesnt> [https://perma.cc/U9JM-67DH] (“There has been no big push for licensing of non-nurse-midwives in Pennsylvania in more than five years.”).

299. 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, 155 (1986) (comparing the preference of physicians for vertical collaborative relationships with the preference of midwives for horizontal collaborative relationships); Deborah Walker, Barbara Lannen & Debra Rossie, *Midwifery Practice and Education: Current Challenges and Opportunities*, 19 ONLINE J. ISSUES IN NURSING, May 31, 2014, <http://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No2-May-2014/Midwifery-Practice-and-Education.html> [https://perma.cc/P7LE-N4NN] (explaining the restrictive challenges faced by midwives because of restrictive legislation and prescriptive authority).

300. See Anna Gorman, *California Lawmakers Consider Allowing Nurse-Midwives to Practice Without Physician Supervision*, KAISER HEALTH NEWS (Aug. 8, 2016), <http://www.kqed.org/stateofhealth/222385/california-nurse-midwives-may-soon-be-allowed-to-practice-without-physician-supervision> [https://perma.cc/96UW-BEHE].

301. See, e.g., *id.* (discussing the burden of the physician collaborative agreement requirement in areas where there are few or no physicians willing to oversee midwives).

302. See Ciavaglia, *supra* note 298 (noting that midwife-attended home births are common in the Amish and Mennonite communities in Pennsylvania).

midwifery. The market for midwifery malpractice insurance is severely limited; for example, after various carriers dropped CNMs from coverage in the preceding decades, Southern Cross Insurance Solutions formed in 2013 to extend coverage to midwives who attend out-of-hospital births and remains the only viable option for midwives in many jurisdictions.³⁰³ Because midwives have lower patient volumes than hospital-based providers, the insurance model that applies to other birth professionals is cost prohibitive for many midwives.³⁰⁴ For example, in 2018, a CPM in Philadelphia who attended three to six births a month, charging \$4,000–\$5,000 per birth, would have had to pay \$42,000 in annual premiums for liability coverage, making professional midwifery an unsustainable way to earn a living.³⁰⁵ In addition, Amish midwives would require an exemption from the malpractice requirement because they oppose carrying insurance as a matter of religious faith.³⁰⁶

Third, many CPMs reject proposed restrictions on which type of clients they can serve, such as pregnant people carrying twins, those with breech babies, and those who seek support for VBAC. Opponents argue that the risk of complication or loss posed by each of these circumstances is too high for out-of-hospital birth.³⁰⁷ Midwives, however, argue that such restrictions unduly infringe upon their autonomy as providers as well as the autonomy of their clients to weigh risks and benefits and choose their provider accordingly.³⁰⁸ They cite robust risk assessment processes and informed consent protocols that aid midwives in deciding whether they possess adequate skill and training to assist pregnant people in twin, breech, or VBAC deliveries.³⁰⁹

Finally, many CPMs object to the requirement that direct-entry midwives be regulated under the SBOM because doing so would subject midwives to regulation by

303. *About, MIDWIFE PLAN*, <http://www.themidwifeplan.com/about/> [https://perma.cc/KL6M-QAKZ] (last visited Feb. 1, 2021); *see also* Lusero, *supra* note 41, at 427–29 (discussing implications of midwifery’s exclusion from the market for professional liability insurance).

304. *See* McCool et al., *supra* note 228, at 458 (discussing rising liability insurance premiums for midwives).

305. Conversation with Christy Santoro, *supra* note 297. One factor that may contribute to CPM resistance to malpractice insurance requirements is the low rate of home-birth clients filing suit against midwives, leading midwives to weigh the risks and benefits in favor of foregoing an expensive insurance policy. When legal action does result from an adverse outcome, it is usually instigated by a physician or hostile regulator. *Id.*; *see also* Tovino, *supra* note 236, at 82–87.

306. Daniel Kelley, *As U.S. Struggles with Health Reform, the Amish Go Their Own Way*, NBC NEWS (Oct. 6, 2013, 2:09 PM), <http://www.nbcnews.com/healthmain/u-s-struggles-health-reform-amish-go-their-own-way-8C11345954> [https://perma.cc/2U9N-BNCE].

307. *See, e.g.*, Fotsch, *supra* note 273, at 48 (noting disagreement about scope of practice, including VBACs, twin deliveries, and breech births).

308. *See* Nina Martin, *A Larger Role for Midwives Could Improve Deficient U.S. Care for Mothers and Babies*, PRO PUBLICA (Feb. 22, 2018, 10:43 AM), <http://www.propublica.org/article/midwives-study-maternal-neonatal-care> [https://perma.cc/XQ9E-H99T].

309. *See, e.g.*, Sarah McClure, *Choosing a Certified Professional Midwife*, HEARTH & HOME MIDWIFERY, (July 23, 2019), <http://hearthandhomemidwifery.com/blog/certified-professional-midwife> [https://perma.cc/X6HM-45KQ] (discussing the idea that CPMs provide care through informed consent, autonomy, and individualized care). *But see* Anna Claire Vollers, *Midwifery Is Now Legal in Alabama. When Can Midwives Start Delivering Babies?*, AL.COM (May 25, 2017), http://www.al.com/news/2017/05/midwifery_is_now_legal_in_alab.html [https://perma.cc/PCF8-939B] (discussing the concessions midwives made in order to ensure the passage of the bill legalizing midwifery in Alabama, including restrictions on twins, breeches, and VBAC).

members of a competing profession that has historically been hostile to their very existence.³¹⁰ The Pennsylvania SBOM currently regulates not only medical doctors and physician assistants but also radiology technicians, respiratory therapists, nurse-midwives, acupuncturists, oriental medicine practitioners, perfusionists, behavioral specialists, and athletic trainers—a list that includes many professionals whose work is outside the scope of traditional medical education and training.³¹¹ The law requires that the SBOM be comprised of six physicians, two public members, one commissioner, one representative from the Secretary of Health, and one rotating representative from five of the other professions regulated by the SBOM (physician assistants, CNMs, perfusionists, athletic trainers, and respiratory therapists).³¹² This one position rotates every four years, which means that the nurse-midwives have a single representative on the SBOM every twenty years.³¹³ The remaining regulated professions—and any newly licensed profession—have no representation on the SBOM, which drafts rules governing their practice, pursues enforcement actions in the event of wrongdoing, and is empowered to take corrective action.

Until now, CPMs in Pennsylvania have been unwilling to make these compromises in order to enable licensure, despite their interest in a sustainable profession and in expanding access to midwifery by securing public insurance coverage for their services.³¹⁴ It is likely that Pennsylvania will eventually follow its thirty-six sister states that have adopted licensure for midwives, but it remains to be seen what regulatory concessions proponents are willing to make in order to secure licensure.

IV. DISMANTLING BARRIERS: APPLYING ANTITRUST SCRUTINY TO MIDWIFERY REGULATION

The vast body of research discussed in the previous Sections describes an array of health and safety benefits associated with midwifery, the potential for cost savings flowing from better integration of midwifery into maternity care, and consumer demand for the pregnancy and childbirth services offered by midwives. The fact that midwives nevertheless face restrictive regulation in many jurisdictions—sometimes to the extent that it significantly or effectively curbs midwives' ability to practice lawfully—suggests the need for closer scrutiny of the regulatory processes that have pushed midwives to the margins and prevented the growth of a robust midwifery profession in the United States. Midwives are not the first service providers to find themselves outmaneuvered on the

310. See *supra* Part III.A for a discussion of the historical hostility towards midwives.

311. *State Board of Medicine*, PA. DEP'T OF STATE, <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/default.aspx> [https://perma.cc/8AK6-VB6M] (last visited Feb. 1, 2021).

312. *Board Member List*, PA. DEP'T OF STATE, <http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/Board-Member-List.aspx> [https://perma.cc/2W65-WW92] (last visited Feb. 1, 2021).

313. 63 PA. STAT. AND CONS. STAT. ANN. § 422.3(b) (West 2020); see also *Board Member List*, *supra* note 312.

314. The situation in Pennsylvania is further complicated by a subset of direct-entry midwives who oppose all attempts to secure licensure, either due to philosophical opposition to state involvement in midwifery practice or resistance to obtaining the formal credentials necessary to secure a license. Conversation with Christy Santoro, *supra* note 297. Still, other direct-entry midwives require an exemption from any proposed licensure law because they are members of or serve only the religious minority communities. *Id.*

regulatory front by a more powerful constituency. There is a long history of parties seeking redress against their competitors by making constitutional or antitrust claims to challenge unfair and economically protectionist regulation.³¹⁵

On the antitrust front, challengers have faced roadblocks erected by courts' application of state action immunity, making antitrust lawsuits targeting state licensing regulations difficult to win.³¹⁶ But the U.S. Supreme Court's decision in *Dental Examiners* has disrupted prior understandings of the scope of immunity enjoyed by state licensing boards. It may be time to revisit antitrust objections to the onerous and self-interested regulation of midwives by physicians in light of recent developments.

The remainder of this Section offers a brief history of occupational licensing and the rise of self-interested regulatory boards, reviews the challenge posed by antitrust immunity available to licensing boards, describes the significance of the *Dental Examiners* case for state action immunity, and then shows how concerns about public health and safety are merely a pretext for economically exclusionary regulation of midwives by physician-dominated boards that should face antitrust scrutiny.

Widespread occupational licensing began to take hold around the turn of the twentieth century as part of an effort to introduce reforms that would protect public health and safety.³¹⁷ States delegated enforcement of such laws to licensing boards whose membership consisted of individuals who belonged to the group being regulated.³¹⁸ In an early challenge to such efforts, the U.S. Supreme Court held in *Dent v. West Virginia*³¹⁹ that occupational licensing for doctors was a valid exercise of the state's power to regulate in the public interest.³²⁰ In upholding West Virginia's requirement that all physicians obtain a certificate from the state board of health confirming their qualifications to practice, the Court endorsed state legislation that required occupational licensing by state-developed boards.³²¹

Occupational licensing expanded dramatically over the coming decades, justified by the idea that the need to protect the public from unqualified practitioners outweighed the higher cost associated with such regulation, as well as the resulting contraction of

315. In-depth discussion of constitutional scrutiny applied to self-interested licensing boards is beyond the scope of this Article. There is a significant body of literature discussing the limitations of constitutional claims brought against self-dealing boards. See, e.g., David E. Bernstein, *The Due Process Right to Pursue a Lawful Occupation: A Brighter Future Ahead?*, 126 YALE L.J.F. 287 (2016); Caleb R. Trotter, *Constitutional Landscaping: An Analysis of Occupational Regulations of Landscape Contractors in the United States*, 58 S. TEX. L. REV. 367 (2017); Will Clark, Comment, *Intermediate Scrutiny as a Solution to Economic Protectionism in Occupational Licensing*, 60 ST. LOUIS L.J. 345 (2016); Carolyn R. Cody, Comment, *Professional Licenses and Substantive Due Process: Can States Compel Physicians To Provide Their Services?*, 22 WM. & MARY BILL OF RTS. J. 941 (2014).

316. Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1093–94 (2014).

317. See NAT'L CONFERENCE OF STATE LEGISLATURES, *THE EVOLVING STATE OF OCCUPATIONAL LICENSING* 5–6 (2d ed. 2019).

318. *Id.* at 3.

319. 129 U.S. 114 (1889).

320. *Dent*, 129 U.S. at 128.

321. *Id.*

economic liberty.³²² In fact, occupational licensing has expanded to include over eight hundred occupations in the United States.³²³ One-third of American workers now require a license in order to be able to perform their jobs, and as a result, one-third of working adults operate under some form of professional self-regulation.³²⁴ In service of this self-regulation, oversight boards were populated by members of the regulated profession on the understanding that only such individuals had the expertise needed to craft appropriate and efficient rules for entry into the profession and continued practice.³²⁵ As Aaron Edlin and Rebecca Haw have noted about these historical developments, “[t]hus, the board-as-cartel was born.”³²⁶

Economists have detailed the impact of licensing restrictions on the cost of services, identifying four categories of significance: (1) barrier to entry into the profession, (2) establishment of rules of practice that restrict competition, (3) suppression of interstate competition by recognizing licenses only from the board’s own state, and (4) adjustment of the scope of practice in order to bring more potential competitors within the ambit of the licensing scheme.³²⁷ In addition, research suggests that scope of practice regulations tend to affect “low-cost competitors that operate at the fringes of an established profession.”³²⁸

The Sherman Antitrust Act,³²⁹ which exists to promote robust competition, prohibits “every contract, combination . . . or conspiracy, in restraint of trade” and any “monopoliz[ation], attempt[ed] . . . monopoliz[ation], or combin[ation] or conspir[acy] to monopolize.”³³⁰ Although licensing requirements are effectively agreements among competitors to create barriers to entry into the profession and thus should attract Sherman Act scrutiny, the Supreme Court has interpreted antitrust law to provide immunity in situations like those involving state licensing boards. In *Parker v. Brown*,³³¹ the Court recognized antitrust immunity for state action, shielding state governments (and those entities to which a state delegates authority) from federal antitrust liability.³³² This protection extends to all entities clearly authorized and “actively supervised” by the state to act in a way that restricts competition through licensing.³³³ One effect of this antitrust

322. See NAT’L CONFERENCE OF STATE LEGISLATURES, *supra* note 317, at 2 (noting that up to 25% of workers today require a license); Edlin & Haw, *supra* note 316, at 1096–98 (explaining the increase in licensing and how licensing boards abuse their power to reduce competition).

323. Morris M. Kleiner, *Occupational Licensing*, 14 J. ECON. PERSP. 189, 190 (2000).

324. Edlin & Haw, *supra* note 316, at 1103.

325. *Id.* at 1111.

326. *Id.*

327. *Id.* at 1112.

328. *Id.*

329. 15 U.S.C. §§ 1–38 (2018).

330. *Id.* §§ 1–2.

331. 317 U.S. 341 (1943).

332. *Parker*, 317 U.S. at 350–52.

333. See, e.g., *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum Inc.*, 445 U.S. 97, 105 (1980) (quoting *Lafayette v. La. Power & Light Co.*, 435 U.S. 389, 410 (1978), *superseded by statute*, Local Government Antitrust Act of 1984, Pub. L. No. 98-544, 98 Stat. 2750, *as recognized in* *Sakamoto v. Duty Free Shoppers, Ltd.*, 764 F.2d 1285 (9th Cir. 1985)).

immunity is that state occupational licensing boards have become a “massive exception to the [Sherman] Act’s ban on cartels.”³³⁴

The potential for applying antitrust scrutiny to state regulatory boards changed in 2015 when the Supreme Court decided the *Dental Examiners* case. The Court held that, in order to enjoy state action immunity from federal antitrust liability, state licensing boards that are predominantly composed of market participants must satisfy two requirements: (1) the challenged restraint on trade must be “one clearly articulated and affirmatively expressed as state policy,” and (2) the “policy [must] be actively supervised by the State.”³³⁵ In this case, the Federal Trade Commission (FTC) alleged that the North Carolina board’s action to exclude non-dentists from the market for teeth whitening services represented an anticompetitive and unfair method of competition.³³⁶ The FTC rejected the board’s public safety justification, noting “a wealth of evidence . . . suggesting that non-dentist provided teeth whitening is a safe cosmetic procedure.”³³⁷ The board appealed the FTC’s decision, claiming exemption from federal antitrust liability under existing precedent.³³⁸

The Court applied the rule from *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*,³³⁹ which “stems from the recognition that ‘[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State.’”³⁴⁰ It made clear that the active supervision test articulated in *Midcal* is an “essential prerequisite of *Parker* immunity for any nonsovereign entity—public or private—controlled by active market participants.”³⁴¹ The Court then clarified the requirements of active supervision on the part of the state: (1) the supervisor must review the substance of the anticompetitive decision (not merely the process), (2) the supervisor must have the power to veto or alter decisions to conform them with state policy, and (3) the state supervisor may not be an active market participant.³⁴² In addition, the “mere potential for state supervision is not an adequate substitute for a decision by the State.”³⁴³

Until the *Dental Examiners* decision, courts had interpreted antitrust federalism to “shield licensing boards from the Sherman Act despite the fact that boards often look and act like [Section] 1’s principal target.”³⁴⁴ But with *Dental Examiners*, the Court

334. Edlin & Haw, *supra* note 316, at 1095.

335. N.C. State Bd. of Dental Exam’rs v. FTC, 574 U.S. 494, 504 (2015) (quoting FTC v. Phoebe Putney Health Sys., Inc., 568 U.S. 216, 225 (2013)).

336. *Id.* at 501.

337. *Id.* at 502 (omission in original) (quoting Application to the Petition for a Writ of Certiorari at 123a, *Dental Exam’rs*, 574 U.S. 494).

338. *Id.* at 501.

339. 445 U.S. 97 (1980).

340. Patrick v. Burget, 486 U.S. 94, 100 (1988) (alteration in original) (quoting Hallie v. Eau Claire, 471 U.S. 34, 47, *superseded by statute*, Local Government Antitrust Act of 1984, Pub. L. No. 98-544, 98 Stat. 2750, *as recognized in* Sakamoto v. Duty Free Shoppers, Ltd., 764 F.2d 1285 (9th Cir. 1985)).

341. *Dental Exam’rs*, 574 U.S. at 510.

342. *Id.* at 515.

343. *Id.* (quoting FTC v. Ticor Title Ins. Co., 504 U.S. 621, 638 (1992)).

344. Edlin & Haw, *supra* note 316, at 1099.

demonstrated its “appetite for stopping cartel-like abuses of antitrust immunity.”³⁴⁵ The significance of this development for licensed and licensure-seeking midwives, along with members of other professions subject to exclusionary regulation, rests in the possibility for recourse when physician-dominated boards enact unduly restrictive regulation in order to prevent competition in the market for childbirth services. The Court spoke clearly and with a strong voice on this point: “active market participants cannot be allowed to regulate their own markets free from antitrust accountability.”³⁴⁶

Notably, in affirming the FTC’s analysis, the Court dispensed with the idea that blanket public health and safety rationales can suffice to protect anticompetitive professional licensing from scrutiny. Boards have used such justifications to defend exclusionary regulations for other health care service providers, including nurse practitioners and physician assistants.³⁴⁷ Likewise, in the context of midwifery regulation, boards regularly accept physician arguments that collaborative agreements, scope of practice restrictions, and limitations on prescriptive authority are necessary to protect public health and safety.³⁴⁸ But recent comprehensive research on the regulation of midwifery practice shows the opposite is true.

The AIMM study mapped the extent to which midwives are restricted or integrated in mainstream maternity care in their respective states.³⁴⁹ Researchers then took those integration scores and compared them to a variety of maternal and infant health measures reported by the state.³⁵⁰ They found a clear association between the degree of midwifery integration—which includes the degree to which midwives are able to practice to the full extent of their training, free from inappropriately restrictive regulation—and health outcomes for pregnant people and infants.³⁵¹

Specifically, higher integration scores in the AIMM study were significantly associated with higher rates of spontaneous vaginal delivery, vaginal birth after cesarean, and breastfeeding, as well as lower rates of obstetric interventions, preterm birth, low birth weight infants, and neonatal death.³⁵² The research team also noted that lower integration scores were associated with race-specific outcomes, especially higher rates of neonatal mortality, suggesting that greater integration of midwives and the associated reductions in neonatal mortality and preterm birth (as well as increased breastfeeding

345. *Id.* at 1101.

346. *Dental Exam’rs*, 574 U.S. at 505 (“The national policy in favor of competition cannot be thwarted by casting . . . a gauzy cloak of state involvement over what is essentially a private price-fixing arrangement.” (omission in original) (quoting *Cal. Retail Liquor Dealers Ass’n. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 106 (1980))).

347. *See, e.g.*, Edlin & Haw, *supra* note 316, at 1107–08 (discussing regulation of physician assistants and nurse practitioners to protect physicians from meaningful competition in the provision of services that fall within the scopes of practice for physicians, physician assistants, and nurse practitioners).

348. *See* Vedam et al., *Mapping Integration*, *supra* note 270, at 3–4 (reflecting various restrictions placed on midwives by their oversight boards).

349. *Id.*; *see supra* Part III.B.2 for a discussion of regulatory restrictions on midwives and the impacts of those restrictions.

350. *See* Vedam et al., *Mapping Integration*, *supra* note 270, at 10–11.

351. *Id.*

352. *Id.* at 8. Researchers found significant differences in newborn outcomes accounted for by integration scores, even after controlling for the proportion of Black births in each state. *Id.*

success) could result in significant long-term health benefits for African American mothers.³⁵³

There is a long history of competition between physicians and midwives in the United States, which manifests in the form of professional distrust, regulatory hostility, and, sometimes, harm inflicted on patients who need to transfer from a midwife's care to a physician's care.³⁵⁴ Armed with research that clearly shows the health benefits of midwifery care, advocates should seize upon the opening created by the Supreme Court's *Dental Examiners* decision and challenge anticompetitive forms of midwifery-restrictive regulation that are promulgated by physician-dominated licensing boards. Such regulation does not benefit consumers by protecting their health and safety or achieving some other pro-consumer goal; rather, restrictive regulation limits entry into the profession and integration of midwives into mainstream maternity care—which the AIMM study shows does not improve public health.³⁵⁵ Claims to the contrary use public health and safety merely as a pretext to enact exclusionary regulation of midwives to protect the economic self-interest of physicians. Midwifery advocates should assess the regulatory landscape in their states to determine whether the threat of Sherman Act antitrust scrutiny could open the door to midwifery-promoting regulatory reform.

V. STRATEGIC OPPORTUNITIES FOR MIDWIFERY ADVOCATES

This Article tells the story of a maternity care system in need of structural reform to improve maternal and infant health outcomes, reduce costs to the health care system, eliminate coercion and mistreatment by health care providers, and make birth experiences better for pregnant people and their families. Longstanding problems with maternity care in the United States have been exacerbated and made even more visible by the impact of COVID-19.³⁵⁶ This Article also tells the story of regulatory overreach, as physician-dominated licensing boards (and physician-influenced state legislatures) regulate midwives to the margins of maternity care or exclude them altogether—instead of enabling them to occupy their proper place as primary providers of care for people experiencing low-risk pregnancy. In light of the onerous restrictions many midwives—both nurse-midwives and direct-entry midwives—face under state law, there is a compelling need for most states to rework their midwifery licensing regimes in favor of a model that uses reasonable regulation to balance the protection of consumer health and safety with providing midwives the freedom to practice to the full extent of their training and credentials. To that end, this Article offers several suggestions about strategic opportunities for midwifery advocates in the current regulatory moment.

First, regulatory board reform should be a priority for midwifery advocates in order to eliminate the ability of members from dominant professions to regulate their economic

353. *Id.* at 11.

354. *See, e.g.,* Rojas-Burke, *supra* note 250 (discussing physicians' hostility towards midwives and home births).

355. *See* Vedam et al., *Mapping Integration*, *supra* note 270, at 10–11.

356. *See supra* notes 26–32 and accompanying text.

competitors into the margins or out of existence altogether.³⁵⁷ In recent years, budget constraints have prompted states to minimize the creation of new boards in favor of combining newly regulated professions with established professions under the same regulatory apparatus.³⁵⁸ The result is that certain agencies, such as boards of medicine—which are properly charged with overseeing the regulation and discipline of medical practitioners—have found the scope of their regulatory ambit increased to include widely varying professions like athletic trainers and acupuncturists, along with more relevant professions like physician assistants.³⁵⁹ Such changes undermine the principle of professional self-regulation, where practitioners with substantive knowledge and training in the field use their expertise to craft appropriate and reasonable regulation of members of the profession. However, they also create a host of potential strategic allies for midwifery advocates to join forces with against irrational (or ill-informed) regulation by members of a different profession.

Pennsylvania offers a useful illustration of certain dynamics in state licensing that midwives could harness to advance their interests. As discussed in Part III.C, the Pennsylvania State Board of Medicine is responsible for regulating ten separate professions, including many professionals who are not medical providers and therefore whose work falls outside the scope of expertise of the physician members of the SBOM.³⁶⁰ Furthermore, although the list of regulated professions has grown, the Commonwealth has not increased the size of the SBOM's membership to include representatives of the newly regulated professions; instead, one of the board positions rotates every four years among physician assistants, CNMs, perfusionists, athletic trainers, and respiratory therapists.³⁶¹ The remaining professions entirely lack representation on the SBOM responsible for regulating and disciplining their members.

Pennsylvania's naturopathic doctors won a sixteen-year campaign for state recognition of their professional credential when legislation regulating naturopaths was signed into law in November 2016.³⁶² However, the legislature refused to grant naturopathic doctors full licensure and instead created a registration system, a reflection of the political push against the cost of creating newly licensed professions—even where doing so serves the public interest.³⁶³ The practical impact of this decision remains to be

357. See Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, 105 CALIF. L. REV. 1567, 1570 (2017) (“The dirty secret behind occupational licensing boards is that very little of what they do resembles governmental activity.”).

358. See, e.g., MINN. HEALTH LICENSING BDS., BIENNIAL REPORT, JULY 1, 2012 TO JUNE 30, 2014 (2014), http://mn.gov/boards/assets/Biennial%20Report%202012-2014_tcm21-52744.pdf [<https://perma.cc/8JC2-UUWT>].

359. See *id.* at 70.

360. *State Board of Medicine*, *supra* note 311.

361. 63 PA. STAT. AND CONS. STAT. ANN. § 422.3(b) (West 2020); see also *Board Member List*, *supra* note 312.

362. Jeff Beddow, *Pennsylvania Governor Signs Naturopathic Medicine Bill*, ASS'N ACCREDITED NATUROPATHIC MED. COLLS. (Nov. 3, 2016, 3:29 PM), <http://www.globenewswire.com/news-release/2016/11/03/886543/0/en/Pennsylvania-Governor-Signs-Naturopathic-Medicine-Bill.html> [<https://perma.cc/Q3LV-GDUJ>].

363. Wesley Venteicher, *New Pa. Law Would Have Naturopaths Be Registered*, TRIB LIVE (Nov. 7, 2016, 7:06 PM), <http://archive.triblive.com/news/new-pa-law-would-have-naturopaths-be-registered/> [<https://perma.cc/NK7Y-TY9X>].

seen, as the naturopathic doctors are still engaged in a regulatory process to define their scope of practice and other provisions regarding how naturopathic doctor oversight will operate in a regulatory structure that is already overburdened.

Because there are so many members of regulated professions whose interests are not well served (and whose patients and clients are not well served) by such a regulatory hodgepodge, there may be opportunities for interprofessional collaboration to demand reform of regulatory board structures more broadly, including any necessary redistribution of resources from long-time regulated professions to newer participants in the regulatory process.³⁶⁴ Depending on the particular landscape and regulatory structure in any particular state, midwives might explore one of several options for regulatory realignment.

One option might entail midwives joining with other nonmedical providers of holistic services to create an allied health professionals board, populated with representatives from each of the participating professions. Another possibility would be to pursue the creation of a Board of Maternal and Child Health to oversee nurse-midwives, direct-entry midwives, and lactation consultants, as well as to administer a registration or quasi-license system for doulas—likely to be a necessary precursor to Medicaid reimbursement for doula services.³⁶⁵

Finally, a third option is the creation of standalone midwifery boards with the sole authority and responsibility for regulating midwives. While this may be the most challenging option to secure politically, given the costs associated with establishing new licensing boards without a high volume of licensees, there are creative options for diffusing likely economic objections. For example, South Dakota advocates engaged in private fundraising to provide the start-up costs for an independent midwifery regulatory board.³⁶⁶ A fully independent licensing board protects midwife autonomy to determine professional guidelines and oversee disciplinary actions without politically motivated interference by hostile medical professionals who are motivated to diminish the role of midwives in childbirth care. While the cause of regulatory reform may not have the same appeal as advocating for midwives, those who care about effecting meaningful change in midwifery access and integration should engage this issue and look for opportunities and alliances.

A second reason midwifery advocates should consider pursuing regulatory board reform is the strategic opening created by the Supreme Court's *Dental Examiners* decision.³⁶⁷ Since the decision was issued in 2015, states have grappled with a barrage

364. Where appropriate, pursuing interprofessional collaboration could also ease the burden of financial constraints on the midwifery profession and enable a greater return on investment for resources allocated to advocacy. See Lusero, *supra* note 41, at 419–20 (discussing financial and practical limitations for midwives in engaging professional lobbying services and mobilizing constituencies, in contrast to the medical profession).

365. See, e.g., ASTEIR BEY, AIMEE BRILL, CHANEL PORCHIA-ALBERT, MELISSA GRADILLA & NAN STRAUSS, *ADVANCING BIRTH JUSTICE: COMMUNITY-BASED DOULA MODELS AS A STANDARD OF CARE FOR ENDING RACIAL DISPARITIES* 3–4 (2019) (discussing New York State's Medicaid Doula Pilot program).

366. See Debbie Pease, *Midwife Regulatory Fund*, GOFUNDME (Nov. 28, 2016), <http://www.gofundme.com/f/MoreMidwives4SD> [<https://perma.cc/ZW8J-2EZ2>]; see also *South Dakota Board of Certified Professional Midwives*, S.D. DEP'T OF HEALTH, <http://doh.sd.gov/boards/midwives/> [<https://perma.cc/VAV2-M42Y>] (last visited Feb. 1, 2021).

367. *N.C. Bd. Of Dental Exam'rs v. FTC*, 574 U.S. 494 (2015).

of lawsuits against licensing boards.³⁶⁸ Some states, like Georgia, have decided to take preemptive action, reassessing their delegation of state power to regulatory boards dominated by members of the regulated profession in order to come voluntarily into compliance with the *Dental Examiners* decision.³⁶⁹ All states share a desire to avoid the taint of self-interested regulators using the power of their position to enact oppressive forms of regulation targeting their economic competitors. As states grapple with the implications of *Dental Examiners*, there may be opportunities for midwifery advocates to lobby other government agencies or legislators, using the specter of antitrust liability to generate political will in favor of a more liberalized regulatory environment for midwives.

Finally, there may be opportunities for pro-midwifery maternity care reform in the wake of the pandemic, as pregnant people continue to demand access to midwife-attended community births. States that have relaxed their medical licensing rules on an emergency basis in order to bring out-of-state providers to help in virus hot spots may find that traditional objections to licensing direct-entry midwives and liberalizing the regulation of all midwives are harder to justify, especially in the face of consumer demand and physician shortages.³⁷⁰ The logistical challenges of segregating healthy and COVID-positive pregnant patients, while ensuring appropriate staffing in maternity care departments, may inspire a resurgence of interest in investing in freestanding birth centers that can accommodate healthy, low-risk patients and provide a safer alternative to hospital-based birth. Moreover, a desire to avoid the heightened risk of virus transmission during surgery may prompt intervention-oriented physicians to turn to midwife colleagues for approaches that are less likely to lead to risky procedures.

CONCLUSION

As the health care system continues to adapt to meet the challenges of the COVID-19 pandemic and future health crises, new opportunities are emerging for interprofessional collaborative responses to the challenges of providing safe, high-quality, and respectful maternity care during a pandemic and will likely serve as a catalyst for elevating the essential role of midwives in providing that care. Strengthening the position of midwives and integrating midwives into mainstream maternity care will expand access to midwifery care, improve maternal and infant health outcomes, and promote better birth for all.

368. Allensworth, *supra* note 357, at 1571.

369. *Id.* at 1580 n.59.

370. See, e.g., Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency, N.Y. Exec. Order No. 202.18 (Apr. 16, 2020) (allowing midwives who have unencumbered licenses but who are not registered in New York to practice midwifery without civil or criminal penalty related to lack of registration); see also Alexa Richardson, *Medical Licensure Law Suspensions During COVID-19 Present Opportunity for Change*, HARV. L.: BILL OF HEALTH (Apr. 23, 2020), <http://blog.petrieflom.law.harvard.edu/2020/04/23/medical-licensure-laws-covid19/> [<https://perma.cc/A7CD-9RUK>] (“The collective rollback of licensure laws is an opportunity for states to reexamine their priorities around provider licensing . . .”).