Midwifery Is Not the Practice of Medicine

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For the great majority of American women, the right to choose the place and manner of giving birth has quietly, but continually, narrowed. In just half a century, allopathic physicians in the United States have enticed ninety-nine percent of us into their places of business (hospitals) for childbirth, forced on us a medical model of birth that has never been proven safe or beneficial, raised the price of services which have diminished in quality and quantity, and lobbied state legislatures for laws that would require us to submit to their exclusive control during pregnancy and childbirth.

Unfortunately, the role of obstetrics has never been to help women give birth. There is a big difference between the medical discipline we call "obstetrics" and something completely different, the art of midwifery. If we want to find safe alternatives to obstetrics, we must rediscover midwifery. To rediscover midwifery is the same as giving back childbirth to women. And imagine the future if surgical teams were at the service of the midwives and the women instead of controlling them.3


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1. When feminists speak about choice, the principal topic is often abortion and the right to terminate pregnancy. The lack of choice in childbirth, however, is beginning to attract the interest of today's feminist political mainstream. Many organizations concerned with women's rights are in the process of broadening their view of reproductive rights to include midwifery. For example, in Florida, the following organizations supported or lobbied for the Florida midwifery bill which passed in 1992: the Florida chapter of the National Organization for Women, Florida Healthy Mothers/Healthy Babies, the Academy of Florida Trial Lawyers, the Florida Women's Political Caucus, and the Florida chapter of the American Association of University Women. Interview with Beth Swisher, legislative lobbyist, Florida Midwives Association (Mar. 6, 1992).

2. Allopaths are known simply as "doctors" or "physicians" today. "Allopathy" is a "method of treating disease with remedies that produce effects different from those caused by the disease itself." AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 95 (3d ed. 1992). Allopathy can be distinguished from other healing systems such as osteopathy, chiropractic, homeopathy, and naturopathy.

3. Dr. Michel Odent, Address at the Meeting of the National Alliance of Parents and Professionals for Safe Alternatives in Childbirth (Aug. 16, 1986). Dr. Odent was formerly the director of the state hospital in Pithiviers, France, and is presently Director of the Primal Health Institute in London. The Institute researches the long-term health effects of medical interventions and other factors from the beginning of pregnancy to the end of infancy.

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Although obstetricians worldwide use the same sophisticated technology and drugs in pregnancy and childbirth as American physicians, doctors in other countries use them differently. 4 Doctors in the country with the lowest infant mortality rate, Japan, use little or no drugs and are much slower to interfere with the natural process of birth. 5 In the United States, the economic alliance between doctors and the producers of technological equipment has obstructed preventive maternity care. “Medical priorities are set by the medical industrial complex, which focuses on providing health care at a profit.” 6

In Europe, the infant mortality rate is significantly less than in the United States. 7 An important attitudinal difference accompanies this statistical difference. Europeans consider birth to be a normal event, and midwives deliver the majority of babies. 8 The European Economic Community’s standards for midwifery education and training programs require three years of intensive study and apprenticeship. 9 Many European midwives 10 work without physician supervision and are not required to study nursing as a prerequisite to midwifery training. 11 Decades of misinformation and misapprehension, on the other hand, have taught women in the United States that birth is a dangerous and pathological event, requiring care by medical specialists. 12 Obstetricians far outnumber midwives in our country and the excellent statistics of the midwives are a well-kept secret. 13

Significantly, Dr. J.G. Kloosterman, former Professor of Obstetrics and Gynaecology at the University of Amsterdam and Director of the Midwives Academy in Holland from 1947 to 1957, has noted that obstetricians cannot improve upon nature: “By no means have we been able to improve spontaneous labour in healthy women. Spontaneous and normal labour is a process, marked by a series of events so perfectly attuned to one another that any interference only deflects them from their optimum course.” 14 The capacity to intervene has led to the notion that intervention is always desirable, even though “[t]here is strong evidence that modern western obstetrics is perverting the physiology of human parturition.” 15 The obstetrician, says Kloosterman, is always on the lookout for pathology, eager to interfere, and the interferences themselves cause pathology that then needs further

5. See id. at 86.
7. Korte, supra note 4, at 84.
8. Id. at 86.
10. In this article “midwife” does not mean certified nurse-midwife unless otherwise specified.
13. See generally id. at 118-24.
15. Id. at 7.
“treatment.”16 Dr. Marsden Wagner, Director of the World Health Organization’s (WHO) European Regional Office, told doctors at an international medical conference in Jerusalem that hospital births “endanger mothers and babies—primarily because of the impersonal procedures and overuse of technology and drugs.”17 The very surroundings and equipment in hospitals increase the risk of iatrogenic, or “doctor-caused,” complications18 which result in excessively high costs to consumers.19

In her 1975 book, Immaculate Deception, Suzanne Arms described the manner in which obstetricians justify preventive interferences during childbirth to “[turn] sloppy old nature into a clean, safe science:"

\[\text{[J]ust in case you hemorrhage, we’ll give you simulated hormones before you expel the placenta; just in case your perineum tears, we’ll make a nice clean incision before delivery; just in case labor tires you out, we’ll give you an early sedative; just in case you need a general anesthesia [for an emergency caesarean], we’ll keep a vein open [put in an IV] and stop you from eating and drinking throughout labor, even if it takes twenty-four hours; and just in case you totally lose control, we’ll knock you right out . . . .}^{20}

According to Arms, it is no wonder that a pregnant woman believes that birth is “loaded with unpredictable horrors that only her doctor can prevent.”21

The “normal” length of the stages of labor has been shortened in medical texts, allowing for earlier medical intervention.22 The length of the stages of labor for hospital births in the 1940s and before was actually longer than the length of labor in home births in the early 1970s in which nature was allowed to take its course.23 Nevertheless, by the late 1960s and 1970s, labor in

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16. See generally id. at 6-7.
17. Hospital Birth Deemed "Too Risky," MOTHERING, Fall 1989, at 75 (citing CHICAGO SUN TIMES, April 2, 1989, at 19). Dr. Wagner is an American pediatrician and epidemiologist. Before the WHO, he worked for fifteen years in the United States in the areas of maternal and child health, and then for fifteen years in Europe in the same fields.
21. Id. at 54.
22. By 1961, the “normal length of labor” for first-time mothers had been shortened by up to 4.6 hours. See, e.g., J. ROBERT WILLSON, MANAGEMENT OF OBSTETRIC DIFFICULTIES 303 (6th ed. 1961). A comparison of the 1971 and 1985 editions of Williams Obstetrics also demonstrates the trend of obstetricians shortening labor for institutional purposes. In 1971, the average length of the second stage of labor was one and one-third hours, LOUIS M. HELLMAN & JACK A. PRITCHARD, WILLIAMS OBSTETRICS 396 (14th ed. 1971), compared to a median length of fifty minutes in 1985. JACK A. PRITCHARD ET AL., WILLIAMS OBSTETRICS 337 (17th ed. 1985).
23. Compare WILLSON, supra note 22, at 303 (sixteen to nineteen hours total) with Lewis E. Mehl, Research on Alternatives in Childbirth: What Can It Tell Us About Hospital Practice?, reprinted in 1 21ST CENTURY OBSTETRICS NOW! 171, 199 (David Stewart & Lee Stewart eds., 1977)(average of thirteen and one-half hours). See also BARBARA KATZ ROTHSMAN, IN LABOR: WOMEN AND POWER IN THE BIRTHPLACE
hospital births was nearly five hours shorter than in home births, with an apparent increase in fetal distress and other complications. Hospitals and doctors push the birth process along to assure that a certain number of deliveries will occur when the maximum number of personnel are available—in other words, during office hours. Waiting for the natural process to occur spontaneously does not serve "institutional needs."

Although prolonging a pregnancy beyond forty-two weeks can be risky, inducing labor does not increase the baby’s chances of survival. Drug-induced labor after forty-two weeks, however, is a routine practice. Hospital rituals and interventions in the birth process comfort the obstetrician who may otherwise have to deal with feelings of uncertainty about the birth. By managing normal birth in the same way as abnormal birth, doctors make each birth more predictable.

If professional midwives conducted the majority of births, women with completely healthy pregnancies could feel protected from unnecessary obstetrical interferences. The midwife screens her clients carefully so that she takes only low-risk cases. She is trained to recognize abnormalities and is fully capable of transferring a woman to a hospital safely during labor if necessary. Dr. Kloosterman estimates that under midwifery care, only three to five percent of healthy mothers would require physician care during delivery. If physicians were consulted in only three to five percent of cases, he states, the infant mortality rate would drop to between two and four in one thousand.

Most women attended by nurse-midwives in our hospitals are poor African-Americans. The white population, which generally tends to be healthier, is more likely to be attended by specialist obstetricians. It seems no coincidence that this healthier, and thus lower-risk, group which is nevertheless more likely to be treated by an obstetrician, has more caesarean sections. If mothers and babies were the paramount concern of the physicians, the increased incidence of caesarean sections would statistically peak within the "higher-risk" black population where their use could be justified. Instead, these expensive

273 (1982)(discussing the impetus to shorten labor).
27. See, e.g., Gibbs, supra note 26, at 293 (describing one hospital ward where induction was routine).
29. ARMS, supra note 20, at 53.
30. Id. at 161.
31. Id.
33. See, e.g., INGRID VAN TUINEN & SIDNEY M. WOLFE, UNNECESSARY CESAREAN SECTIONS: HALTING A NATIONAL EPIDEMIC 36 (1992)(women with health insurance have more caesarean sections).
interventions are applied to those who can pay the most.\textsuperscript{34}  
Economics is the hidden agenda when midwifery regulation is discussed in state legislative sessions. In testimony before legislative committees, the medical lobby overemphasizes the potential of pregnancies to become pathological.\textsuperscript{35}  Though pathology occurs in only a small minority of pregnancies, many legislators are convinced that physician treatment should be required for the safety of mother and infant.\textsuperscript{36}  Implicitly, under this medical model of pregnancy and birth, the profession of midwifery is subordinated and maternity care becomes “the practice of medicine” subject to state statutes that regulate the practice of medicine. No evidence exists, however, that this system is actually safer than home birth with a competent midwife. Public health experts and researchers are recognizing that midwifery will not disturb the system of obstetrics. Instead, international research indicates that the two professions are compatible, complementary, and necessary to each other for an efficient and cost-effective system of care.\textsuperscript{37}  
The fallacy-ridden dominant belief that “home birth is dangerous”\textsuperscript{38}  makes it relatively easy for the medical lobby to convince lawmakers that pregnant women who reject doctor control endanger themselves and their babies and that midwives are safe practitioners only if they are also nurses. Physicians cite the safety of the infant (and, secondarily, the mother) as a primary concern. Doctors have successfully prioritized the rights of the unborn\textsuperscript{39}  and

\textsuperscript{34}  Id.  
\textsuperscript{37}  Kloosterman, supra note 14, at 10; Marsden Wagner, Is Homebirth Dangerous?, BIRTH GAZETTE, Fall 1989, at 16. See generally Rosenblatt, supra note 19. These issues must also be examined in light of the economic crises facing individuals and states today. The typical obstetrician’s income in 1990 (after expenses and malpractice insurance but before taxes) was $202,430. DIANA KORTE & ROBERT SCAER, A GOOD BIRTH, A SAFE BIRTH 66 (3d rev. ed. 1992). That amount is more than four times the average income of practicing midwives. See id. These figures alone suggest that a transition to a primary care system with midwives as the central care provider could realize considerable cost savings.  
\textsuperscript{38}  British statistician Marjorie Tew explains that obsession with comparisons of intended places of delivery (home versus hospital) has continuously obstructed efforts to evaluate the actual methods of intranatal care. Tew, supra note 18, at 662. Home birth has acquired a bad name as a result of a misconstruction of facts. Tew explains that in England, high infant mortality rates started to occur in home settings as the one hundred percent hospitalization policy was implemented in the late 1960s. With most planned births occurring in the hospital, the high mortality rate of unplanned (and unattended) home births was attributed to their home setting. Id. It is reasonable to assume that the same holds true in the United States. See also Michel Odent, Planned Home Birth in Industrialized Countries, in TARGETS FOR HEALTH FOR ALL 5 (World Health Organization, EUR/ICP/MCH/126/4977B, 1991). In this report, Dr. Odent confirmed the safety of home birth with a well-trained attendant. Though prepared at the request of the WHO, the conclusions of the report do not represent official WHO policy. Dr. Marsden Wagner explains, however, that they are “consistent with the WHO recommendations found in Having a Baby in Europe, the Summary Report of the WHO Conference on Appropriate Technology for Birth, Fortaleza, Brazil, 22-26 April, 1985 and the Summary Report of the WHO Symposium on Appropriate Technology Following Birth, Trieste, Italy, October, 1986.” Michel Odent, Planned Home Birth in Industrialized Countries, 17 NAPSAC NEWS, Summer 1992, at 1.  
maintained control over birth against the wishes of the parents who pay their fees. Ironically, consumers are afforded little control even though they, not the physicians, bear the ultimate responsibility of pregnancy and birth.

Strained economic times and grossly high infant mortality rates have led states to consider midwifery as a way to make maternity care accessible and affordable in spite of doctors' protests. In the 1992 Florida legislative session, House Bill 553, proposing the legalization of three-year training schools for direct-entry (non-nurse) midwives, was heatedly debated. Although the direct-entry schools were based on the European training model and the Senate Health Care Committee had studied and recommended passage of the bill, the Florida Medical Association (FMA) opposed it.

The FMA told the lawmakers that "[l]ay midwives do not have the education nor the training to practice without posing [a] serious threat to the public." When asked by the Senate Committee to verify their position with statistics or facts, they could not do so. The space for that requested information was left blank. The FMA wanted the penalty for unlicensed midwifery in the state of Florida increased from a misdemeanor to a felony. The physicians claimed that, unless these "other" midwives were legally placed under obstetrical supervision (like the nurse-midwives), they would refuse to provide emergency back-up services. The bill passed anyway.

Independent non-nurse midwives, not subject to doctor control, are unwelcome business competition. In 1990, the U.S. Department of Health and Human Services reported that "female with delivery" was the most common

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40. Telephone Interview with John Wilson, Staff Director, Florida Senate Health Care Committee (Oct. 13, 1993). Similar legislation (Senate Bill 1066 and House Bill 1513) had been introduced in the Florida legislature in 1991. The Florida Medical Association (FMA) and the Florida Obstetric and Gynecologic Society wrote a joint letter to Florida Senators strongly opposing SB 1066 in March of 1991. The letter stated that "[l]ay midwifery services are "inferior," and labeled the practice of lay midwifery the "deliberately endangering [of] the lives of mothers and infants." Letter from Amy J. Young, Governmental Consultant, to Florida State Senators (Mar. 29, 1991)(on file with author). A letter from B.L. Stalnaker, who supervises residents in obstetrics and gynecology in northwestern Florida, to a Florida Representative urged that the licensure of lay midwifery "must be soundly defeated if we are committed to the best possible health care for both mother and child." Letter from B.L. Stalnaker, Director, Northwest Florida Residency Program in Obstetrics and Gynecology, Inc., to Representative Bo Johnson, Florida House of Representatives (April 15, 1991)(on file with author). Immediately before the vote on HB 1513, Representative Ben Graber distributed on the floor of the Florida House of Representatives a handout listing emergency conditions that can develop and suggesting that lay midwives would not be able to deal with these conditions. Memorandum from Representative Ben Graber, Florida House of Representatives (undated)(on file with author). What Representative Graber's handout does not mention is that he is a Board-certified obstetrician. See John P. Phelps, Clerk of the House, The Clerk's Manual 1990-1992: Compiled for Use by The House of Representatives of the State of Florida (February 1991)(on file with author). Heated debate continued through the passage of House Bill 553 in 1992. Telephone Interview with John Wilson, supra.

41. See generally SUSAN D. WILLIAMS, FLORIDA MEDICAL ASSOCIATION, RESPONSE TO FLORIDA SENATE QUESTIONNAIRE (1990)(on file with author). See also Letter from Young, supra note 40.

42. WILLIAMS, supra note 41, at 1. Ironically, one of the FMA's principal objections to allowing direct-entry midwives to practice was that they lacked "obstetrical backup"—a factor wholly within the control of the physicians, not the midwives. See id.

43. Id.

hospital discharge category.\textsuperscript{45} Since hospital birth is a major source of revenue for most public and private hospitals,\textsuperscript{46} it is understandable that hospital associations join with physicians to lobby against out-of-hospital births.

When independent "direct-entry" midwives attend a laboring woman at home, the facility fee (for a room in a hospital or birth center) is nonexistent. The difference in cost between a home birth with a licensed midwife and a normal hospital birth is considerable. For example, licensed direct-entry midwives in Florida charge $700 to $1600 for their services,\textsuperscript{47} compared with an average of $4500 for a normal hospital birth.\textsuperscript{48}

Nevertheless, economic disincentives often discourage even nurse-midwives from providing home birth services. Even if they can locate physicians who will work with them, insurance companies in most states do not cover the cost of midwifery services if birth is not performed in a hospital or birth center.\textsuperscript{49} Medicaid often does not reimburse midwives for home deliveries.\textsuperscript{50} The National Center for Health Statistics reports that in 1989, out of 4,040,958 births (national total for all races), only 11,383 (.28\%) were planned home births attended by midwives. Of these births, nurse-midwives attended only one-third (.09\%).\textsuperscript{51}

Birth centers\textsuperscript{52} provide a practice place for nurse-midwives who reject the subordinate role forced on them in hospitals. With increasing physician ownership, these centers have been reclassified as "safe" alternatives to hospitals in most states even though physicians are usually not in attendance. A recent study demonstrated that birth statistics of nurse-midwives in birth centers are better than those of nurse-midwives working with obstetricians in hospitals.\textsuperscript{53}

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\textsuperscript{46} Id.
\textsuperscript{47} Labor of Love, MIAMI HERALD, April 29, 1991, at Cl.
\textsuperscript{49} KORTE & SCAER, supra note 37, at 47, 48.
\textsuperscript{50} See, e.g., FLA. STAT. ch. 409.908 (1993)("midwives licensed under chapter 467 shall not receive Medicaid reimbursement for home deliveries conducted for Medicaid recipients").
\textsuperscript{51} NAT'L CENTER FOR HEALTH STAT., supra note 32, at 25.
\textsuperscript{52} Birth centers are nonhospital facilities organized to provide family-centered care for women judged to be at low risk of obstetrical complications. Judith P. Rooks et al., OUTCOMES OF CARE IN BIRTH CENTERS, THE NATIONAL BIRTH CENTER STUDY, 321 NEW ENG. J. MED. 1804 (1989). At true birth centers, there is no induction and no augmentation of labor with oxytocin, no electronic fetal monitoring except for Doppler ultrasound—the sonic aid—there are no drugs for pain relief, except for local analgesia to suture tears in the perineum, very few episiotomies, and no operative deliveries. In many the only equipment is oxygen, and catheters for clearing a baby's airways when they are blocked.
\textsuperscript{53} SHEILA KITZINGER, HOMEBIRTH: THE ESSENTIAL GUIDE TO GIVING BIRTH OUTSIDE THE HOSPITAL 58 (1991). Some states have seen a need to clarify the legal definition of birth centers. For example, Florida defines a birth center as "any facility, institution or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy." FLA. STAT. ANN. ch. 383.302 (Harrison Supp. 1991).
Obstetrical interventions pass for science, even though their use in normal pregnancy is irrational. According to anthropologist Robbie Davis-Floyd, obstetrical interventions fulfill a rational societal function by diminishing our high-tech society's extreme fear of birth. Specific cultural services are performed when obstetricians "bring forth a new social member through a maze of wires and electronic beeps." Obstetrical rituals convey core values that center around science and technology. Belief in them as "necessary" sustains patriarchal institutional management. We let monitors, intravenous devices, and drugs give birth instead of women, turning the bodies of women who give birth into "machines." Faith in technology provides a comfortable refuge from the unknown.

The entrance of women into the field of obstetrics has not made a significant difference in the way obstetricians preside over birth. As a group, female obstetricians tend to conform more to the philosophy of their male colleagues than to that of female midwives. Medical school selection processes, socialization during medical education, the stresses inherent in obstetric residency programs, and the minority status of women in medicine are all factors likely to contribute to female physicians' unwillingness to buck the system. Moreover, medical schools convey the consistent and pervasive message to medical students that technology is always an advantage. There is apparently little difference in the degree to which this "indoctrination" affects female and male obstetricians.

In physician-chosen settings, nurse-midwives must work under "doctor's orders." Outside the hospital, nurse-midwife services are constrained by requirements for supervision by physicians. One commentator, discussing restrictions on nurse-midwifery in the context of malpractice insurance policy, compared physicians and hospitals to lawyers who have worked to prevent paralegals and others from the practice of law:

[M]any professions, including both medicine and law, have erected rather stringent barriers to prevent entry by others who would like to practice in the field. In pure market terms, that cuts directly against private enterprise. In effect, the professionals do not allow open and free competition. . . . I happen to think it's not right. . . . [A]ccess [to independent midwives] is generally contained by requirements for

reported this discrepancy, although the actual figures have not yet been published. Id.
supervision by physicians. If the public were allowed to choose the lower-cost alternative freely, knowingly accepting the risk, I think that there would undoubtedly be more competition in the medical field. I believe nurse-midwives have lower claims frequency and severity rates.63

In hospitals and physician-controlled birth centers, the physician defines what is normal and what is abnormal. Physicians control the training of midwives and the services they can provide. As such, hospital-based nurse-midwifery is thus no real threat to medical control.

The distinction between nurses and midwives has been pointed out by researchers who find the combination of the two professions disturbing. A nurse is trained not to make decisions but to defer to physician authority. Like the physician, the nurse has been taught to expect problems and complications in every birth. The midwife, on the other hand, understands that the birth process seldom requires intervention. Her forte is normal birth, although she is well-trained to recognize and address abnormalities. Her experience at handling normal birth gives her skills that obstetricians do not possess. She serves the mother, not the physician, and although she will quickly transfer the mother to the hospital when the labor deviates from normal expectations, her main role is support and protection so that unnecessary interventions do not occur. From Europe,

there is also evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the U.S. one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation.68

63. See Peter Hiam, Medical Malpractice Insurance, in 2 Legal Principles and Practice in Obstetrics and Gynecology 30, 41 (Max Borten & Emanuel A. Friedman eds., 1990).
64. See Rothman, supra note 23, at 76 (“The only route to professional autonomy for midwives is the demedicalization of childbirth . . . ”).
66. Lesley Page, The Midwife’s Role in Modern Health Care, in The Midwife Challenge, supra note 65, at 251, 254. The midwife may address complications that fall within her scope of practice and training or she may refer the pregnant woman to the appropriate medical practitioner. Id.
67. See Arms, supra note 20, at 155-56; Page, supra note 66, at 254-56.
Midwifery, with its shift of control from the doctor to the mother, is seen as a threat by organized medicine. The superb safety record of birth centers, with their popular “home-like” atmosphere, has been such a threat that hospitals have annexed “birthing rooms” and expanded midwifery service. Most nurse-midwives, however, are employed by physicians who forbid them from providing home-birth services. Control of the practice setting for other nurse-midwives is also strictly regulated by doctors.

Part I of this article will describe the history of the elimination of the American midwife and the concurrent takeover by organized medicine. Part II defines types of midwives in the United States and provides a modern definition. Part III analyzes the differences between the medical model of birth and midwifery. Part IV argues that the legislature is the appropriate forum for reform, especially since attempts at change through the judicial process have failed. Moreover, strong policy arguments exist for reforming the current regime of medical hegemony over childbirth.

I. HISTORY OF THE ELIMINATION OF THE AMERICAN MIDWIFE

The midwife’s traditional role in childbirth went unchallenged until delivering babies became both a science and a business. In the Colonial period, midwives attended the majority of births. Childbirth was a social, not a
medical event, in which women offered aid and comfort to each other during the delivery. Women relatives and friends served and assisted the laboring mother. Physicians’ participation in childbirth in this period was limited to attendance at the most difficult births, and was prompted by the perceived need for the use of instruments.

After 1750, men with European medical training began to practice in the American colonies. The first colonial medical school was founded in 1765, and by the first decade of the nineteenth century, midwifery was taught at five American medical schools. By this time, physicians were beginning to call their participation in childbirth “obstetrics”—“a scientific-sounding title free of the feminine connotations of the word midwife.” Physicians in both England and the United States were transforming childbirth into a medical/scientific event. Nevertheless, American doctors first assumed that midwives would continue to handle normal deliveries and that they would intervene only in difficult cases. Some limited training opportunities in the “obstetrick art” were extended to female midwives; by 1820, however, physicians’ interest in instructing midwives had ceased to exist. As early as 1760, a well-known journalist stated that the growing popularity of the “medical men” and their instruments was directly related to the ability of men to convince women that they had superior skills, that childbirth was dangerous, and that midwives were incompetent. Physician-assisted birth became an isolating experience for the mother. The doctor often dismissed family and supportive friends because they were a hindrance to his practice. Despite the disruption to traditional rituals of childbirth that the physician’s presence caused, upper- and middle-class women appreciated his superior skills in managing pathological cases and his reputation for having acquired scientific

73. WERTZ & WERTZ, supra note 72, at 2.
74. Scholten, supra note 72, at 147.
75. Id. at 145; WERTZ & WERTZ, supra note 72, at 29.
76. Scholten, supra note 72, at 146.
77. Id. at 146; WERTZ & WERTZ, supra note 72, at 49.
78. Scholten, supra note 72, at 146-48; see also WERTZ & WERTZ, supra note 72, at 31-46.
79. WERTZ & WERTZ, supra note 72, at 44.
80. Scholten, supra note 72, at 147-48.
81. Id. at 148. Birth manuals after 1800 sought to discredit the midwife and the writings of doctors in these publications implied that “women who presumed to supervise births had overreached their proper position in life.” WERTZ & WERTZ, supra note 72, at 56. No “true” woman, they implied, would want to attain the skills and knowledge needed to deliver a child. Id. Women were likewise excluded from medical schools until 1847, when Elizabeth Blackwell was accepted by New York Medical College. After graduating at the top of her class she had to go to Paris and London to obtain clinical experience because no American hospital would allow her to practice. Id. at 59. One stated rationale was that hormonal changes occurring during menstruation resulted in a “condition” synonymous with temporary insanity. Id. at 57. Women were said to be incapable of mastering the languages, chemistry, and mathematics that were prerequisites to medical training. One doctor wrote: “Their feelings of sympathy are too powerful for the cool exercise of judgment in medical emergencies.” WALTER CHANNING, REMARKS ON THE EMPLOYMENT OF FEMALES AS PRACTITIONERS IN MIDWIFERY 1 (1820), quoted in Scholten, supra note 72, at 148.
82. ROTHMAN, supra note 23, at 53.
83. Scholten, supra note 72, at 150.
84. Id.
knowledge.\textsuperscript{85} Dramatic rescues by doctors convinced large groups of people that the physician was necessary to childbirth.\textsuperscript{86} Increasingly, physicians were called to attend normal deliveries as well as problematic ones. In the nineteenth century, upper- and middle-class families became convinced that normal pregnancy was so potentially or actually abnormal that it constituted a medical condition.\textsuperscript{87}

The American midwife gave way to the medical doctor as the chief birth attendant for the middle and upper classes during the nineteenth century.\textsuperscript{88} Physicians endorsed more extensive interventions in birth, moving away from the conservative approach of the midwives.\textsuperscript{89} In spite of this more interventionist care, the maternal and infant death rates were much higher in the United States than in European countries.\textsuperscript{90}

The successful strategy of the physicians was to develop a demand for a "higher standard of obstetrics"; normal pregnancy and delivery were said to be a fallacy.\textsuperscript{91} The actual dangers of birth were greatly exaggerated,\textsuperscript{92} and routine medical intervention during birth was firmly established as "necessary."\textsuperscript{93} Upper- and middle-class American women who could afford to use male practitioners were taught to value obstetric skills and fear the dangers of childbirth to the point that no precautions were considered excessive.\textsuperscript{94} At the same time, most newly graduated doctors had no clinical experience in attending birth.\textsuperscript{95}

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\bibitem{85} Id. at 146-47.
\bibitem{86} Id. at 147.
\bibitem{87} See WERTZ & WERTZ, supra note 72, at 62-73 (doctors increasingly used medical procedures and instruments to establish the centrality of their role in childbirth).
\bibitem{88} Id. at 47; Litoff, supra note 36, at 3. The traditional midwife would have been completely wiped out in the United States if a large influx of immigrants hadn't arrived here from Europe beginning in the mid-nineteenth century. The immigrants brought their own midwives, who came from a long, well-respected tradition. These settlers were located mostly in the northeast and midwest. The south also found many midwives still delivering babies of poor blacks. Almost ninety percent were delivered by midwives, many with little or no formal training. \textit{Id.} at 3-4. Even while obstetrical care became prevalent in the United States, European countries saw midwifery continue to flourish and grow. WERTZ & WERTZ, supra note 72, at 71-72. Whereas American women were discouraged from becoming midwives and, even if interested, were forced to pay for their own training, European governments financially supported midwifery training programs and developed midwifery as an integral part of maternity care systems. \textit{Id.} at 44-47. In France, for example, doctors were trained alongside student midwives in the principal maternity hospitals. French midwives supervised normal deliveries and taught the doctors normal birth. \textit{Id.} at 63.
\bibitem{89} WERTZ & WERTZ, supra note 72, at 46-47. To the defenders of the midwives, the doctors said the issues were safety and the proper place of women; they did not talk about their pecuniary motives. \textit{Id.} at 56.
\bibitem{90} Litoff, \textit{supra} note 36, at 5. This remains the case for infant mortality rates. See \textit{infra} text accompanying note 160.
\bibitem{91} Frances E. Kobrin, \textit{The American Midwife Controversy: A Crisis of Professionalization, in Women and Health in America, supra note 72, at 318, 322; WERTZ & WERTZ, supra note 72, at 141.}
\bibitem{92} JEAN DONNISON, MIDWIVES AND MEDICAL MEN: A HISTORY OF THE STRUGGLE FOR THE CONTROL OF CHILDBIRTH 40 (1988); WERTZ & WERTZ, supra note 72, at 58.
\bibitem{93} WERTZ & WERTZ, supra note 72, at 141.
\bibitem{94} Kobrin, \textit{supra} note 91, at 322. See also WERTZ & WERTZ, supra note 72, at 47. In 1910, approximately one-half of all births were attended by midwives, Litoff, \textit{supra} note 36, at xi, but by 1939, 95% of urban women and half of all women gave birth in hospitals. WERTZ & WERTZ, supra note 72, at 133.
\bibitem{95} WERTZ & WERTZ, supra note 72, at 85. The nineteenth century emphasis on modesty discouraged
Early twentieth-century studies disclosed that “maternal mortality rates were lowest in those localities reporting the highest percentage of midwife-attended births.”96 The Children’s Bureau published articles that alerted the country to the many “preventable” deaths that were occurring in childbirth, and their reports prompted studies of the outcomes of both physician and midwife care.97 A national conference was held at the White House in 1925 to announce that “‘the record of trained midwives’ actually ‘surpasses the record of physicians in normal deliveries’”; midwives, the conferees reported, took better care of women in labor because they exhibited patience and let nature take its course.98 Dr. Josephine Baker, who served with the New York City Department of Health for 25 years, established a school in 1911 to train midwives and utilized their services extensively in the City for that time period. By 1921, the infant mortality rate for all of New York City had decreased by one-half.99

Despite strong evidence that the new obstetrical practices were not improving the outcome of childbirth,100 the move toward physician-controlled childbirth continued. Many women perceived hospital stays as the way to alleviate the risks of childbirth.101 “By 1930, only fifteen percent of births were attended by midwives.”102 Nevertheless, puerperal fever, an often fatal condition resulting from infection acquired during labor and delivery,103 was widespread in the maternity wards as well as in physician-assisted home birth.104 This dreaded disease contributed to the image of pregnancy as an
illness, even though it was spread by the doctors themselves.\footnote{105} By the mid-1930s, several factors had contributed to a reduction in the incidence of puerperal fever: a reduction in needless operations; the discovery of antimicrobial drugs such as sulfa and penicillin; blood transfusions; shortening of pathologically long labors; and “a general improvement in women’s health.”\footnote{106} At the same time that hospitals were becoming safer, women were turning to hospitals to avoid pain during childbirth.\footnote{107} By the 1940s, more than half of all births occurred in the hospital;\footnote{108} and by 1950, eighty-eight percent of the public used hospitals for births.\footnote{109} By this time, hospital birth resembled a “production line,” characterized by physician supervision and control, with “every precaution . . . taken to prevent disaster.”\footnote{110} Women often experienced hospital birth as dehumanizing and cruel.\footnote{111}

During the 1960s, women pushed for reform, striving for increased autonomy.\footnote{112} “Natural childbirth” gained popularity as women sought greater safety for themselves and more control over their bodies during the birth process.\footnote{113} The medical profession reacted negatively to this new interest.\footnote{114} From the 1940s to the 1970s, a woman entering the hospital who insisted on natural childbirth was considered “hostile.”\footnote{115} Her request was considered unreasonable because it required too much time. Only private

\footnote{105. Id. at 128. Physician-caused disease is referred to as “iatrogenic.”}
\footnote{106. Id. at 127-28.}
\footnote{107. Id. at 128.}
\footnote{108. Litoff, supra note 36, at 12.}
\footnote{109. Dye, supra note 98, at 339.}
\footnote{110. WERTZ & WERTZ, supra note 72, at 166-67. Wertz and Wertz offer the following description of hospital birth in the mid-twentieth century:}
\footnote{During the 1940s, 1950s, and 1960s, birth was the processing of a machine by machines and skilled technicians. Labor began in one room. The woman often received analgesics to reduce pain and scopolamine to remove the memory of pain. When she was ready to deliver, she was wheeled to the delivery room and placed on a table with “stirrups.” Her arms were strapped down and her legs were strapped high in the air in a bent posture known as the lithotomy position because it was developed first for the removal of bladder stones (hence lithos [stone] and tenein [cut]). She was surrounded by medical machines, anesthesia equipment, resuscitation equipment for the baby, blood-transfusion equipment, and intravenous equipment, equipment to counteract the anesthesia, and equipment to monitor the fetal heart.}
\footnote{Many labors and deliveries alternated between being artificially slowed down and artificially speeded up. Some hospitals had regulations limiting the amount of time a woman was allowed to be in the delivery room. Also, one technique could often require the use of another. Anesthesia was counteracted by oxytocin; episiotomy required local anesthesia; forceps required anesthesia and episiotomy; the lithotomy position required episiotomy.}
\footnote{Id. at 165.}
\footnote{111. For example, in 1957, a maternity nurse wrote to the Ladies Home Journal and called for an investigation of “cruelty in maternity wards.” Letters, LADIES HOME JOURNAL (May 1958), quoted in WERTZ & WERTZ, supra note 72, at 170. Hundreds of women wrote to the Journal telling their stories of poor treatment in the hospitals. Many women complained that they were tied to delivery tables. One said that she felt “exactly like a trapped animal.” Id. at 171, 170. Another woman reported that the delivery room was not “ready” when her baby was about to be born, so her legs were tied together to delay the birth. Id. at 171.}
\footnote{112. Id. at 179.}
\footnote{113. Id.}
\footnote{114. Id. at 190-91.}
\footnote{115. Id. at 191.}
patients who could afford to pay higher prices could convince obstetricians to deliver their babies “naturally.”

In the 1950s, husbands were allowed to stay with their wives during the early stages of labor, but until the 1970s they were forbidden to accompany their wives during labor and birth. The Lamaze program of “prepared childbirth,” initially lauded for transferring some control to the laboring woman, was adopted by hospitals because it helped them promote medical interventions as “natural.” Instead of being educated as to which of the hospital routines were unnecessary or arbitrary, the pregnant woman was taught breathing exercises to help her accept whatever was done to her. Lamaze instruction continued medical domination over women during labor and birth.

As long as women continued to give birth in hospitals, doctors accepted some parts of the new movement toward “naturalness.” The Lamaze method did not significantly interfere with medical control over birth. By 1970, “prepared childbirth” in the hospital was “natural” and included episiotomy, outlet forceps, demerol, and epidural anesthesia, in addition to the Lamaze

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116. Id.
117. Id. at 186.
118. Id. at 193. See also MARJORIE KARMEI., THANK YOU DR. LAMAZE: A MOTHER'S EXPERIENCE IN PAINLESS CHILDBIRTH (1959). The Lamaze method promised no pain in childbirth if the woman practiced certain techniques ahead of time. WERTZ & WERTZ, supra note 72, at 193. Karmel was a strong advocate for the obstetrician. In the first training program that she developed, she wrote:

In all cases the woman should be encouraged to respect her own doctor's word as final. . . . It is most important to stress that her job and his are completely separate. He is responsible for her physical well-being and that of her baby. She is responsible for controlling herself and her behavior.

ROTHMAN, supra note 23, at 90 (quoting ELISABETH BING AND MARJORIE KARMEL, A PRACTICAL TRAINING COURSE FOR THE PSYCHOPROPHYLACTIC METHOD OF PAINLESS CHILDBIRTH (1961)).

119. WERTZ & WERTZ, supra note 72, at 172.
120. See id. at 194-95. The woman was taught that she could “be part of the team” and assist the doctor by following directions. The medical team's outlook was that the baby will “be delivered” with or without the mother's cooperation and the only role they offered her was that of “observer.” She was “expected to be grateful to the . . . staff for the wonderful job they had done.” ROTHMAN, supra note 23, at 178.

The first Lamaze course that was developed in the U.S. incorporated perineal shaves, enemas, delivery tables (women were taught that it was all right “to request politely that only leg and not hand restraints be used”), and episiotomies. Id. at 91. Lamaze instructors are taught that episiotomy is “a merciful aid to the mother.” Id.

Women who used the Lamaze method in the 1960s and 1970s may have felt that it gave them a type of “control.” Id. at 92. Nevertheless, the creators of the Lamaze program did not address such control issues as separation of mother and infant immediately after birth, and breastfeeding. Id. at 91. The husband participates in the training and is taught to assume the position of a “coach” who will give the emotional support that is often lacking in hospital care.

In essence, the method keeps the woman quiet by giving her a task to do, making being a ‘good’—noncomplaining, obedient, cooperative—patient the woman's primary goal. . . . [T]he husband is coopted into doing the [hospital] staff's work, moving the patient through the medical routines as smoothly as possible. Mother, coached by father, behaves herself, while doctor delivers the baby.”

Id. “The Lamaze training system is being changed radically at present, but there are many Lamaze instructors working within the hospital system in which their job depends on subordination and passive cooperation with obstetricians who make the rules.” Letter from Sheila Kitzinger to author (Jan. 19, 1993) (on file with author).

121. WERTZ & WERTZ, supra note 72, at 194.
Unlike the home-birth movement and the midwifery model that support control during birth by the mother herself, "prepared childbirth" does not challenge physician control.\(^{123}\)

II. TYPES OF MIDWIVES & MODERN DEFINITION

According to Dr. J. G. Kloosterman, former director of the Midwives Academy in Holland, the modern midwife should have at least three years of training.\(^{124}\) Part of her training should be in the hospital so that she becomes very familiar with pathology in order to recognize it early and refer cases to obstetricians. Midwives can thus free obstetricians to concentrate on their real task of studying human parturition and handling pathology.\(^{125}\)

There are several types of midwives in the United States. Some midwives are formally educated while others are not. Some are tested and certified while others are not. Some enter directly into midwifery training\(^{126}\) without becoming nurses first and some have been formally educated in both nursing and midwifery. This can be confusing for consumers since, until recently, there have been no agreed-upon professional standards for non-nurse midwives.

To develop those standards has been a challenge for the American College of Nurse-Midwives (ACNM)\(^{127}\) and the Midwives Alliance of North America.
The professional midwife is a primary care provider who independently renders care during pregnancy, birth and the postpartum period to women and newborns in her community. With additional education and training, the professional midwife may render well-woman care and gynecological care. The midwife works with each woman and her family to identify their unique physical, social and emotional needs. Midwifery care occurs within a variety of settings and includes education and health promotion. When the care required extends beyond her abilities the midwife has a mechanism for consultation, referral, continued involvement, and collaboration.129

“Traditional” birth attendants in the United States are empirically or apprentice-trained midwives. Direct experience constitutes the majority of their training. Some states regulate and register them, while many others have made their practice illegal. Their competence and training varies from state to state. Many are well trained and competent, but are not allowed to practice under their state’s laws.130 The term “lay midwife” has no “specific meaning that is widely understood or accepted. It [has been] used to describe all kinds of midwives who may or may not be formally educated, may or may not have met some legal requirements for the practice of midwifery, and may or may not share [a common or near-common] philosophy regarding birth.”131 Thus the term may be used erroneously to discredit well-trained direct-entry midwives.

Modern midwifery in the United States has been thought of, for the most part, as a function performed by nurses. Registered nurses, whether they possess an associate’s degree (generally two years of college) or a bachelor’s degree (generally four years of college), can complete a certificate program

128. Many nurse-midwives protest the banning of independent midwives. Some nurse-midwives joined independent midwives who attended the 1982 ACNM national convention to form the Midwives Alliance of North America (MANA). Id. at 18.
in nurse-midwifery in fourteen months.\textsuperscript{132} If a nurse desires a master's degree in midwifery, however, she must first earn a bachelor's degree (which can be in another discipline) and complete a two-year graduate midwifery program. Whether the midwife trains by the direct-entry route or by the nurse-midwifery route, the American College of Nurse-Midwives states that she must achieve certain core competencies: "The [American College of Nurse-Midwives] believes that the standards for professional midwifery practice should be identical whether nursing is a base for midwifery or not."\textsuperscript{133} Unlike some nurse professionals, the ACNM values competency as the ultimate goal of training and does not push for or require college degrees:

\begin{quote}
[The ACNM] has adopted a policy of opposing mandatory degree requirements for state licensure for certified nurse-midwives. This position is stated in the "Guidelines for State Statutes and Regulations" . . . approved by the ACNM Board of Directors in July 1984 . . . . Because there is no evidence that degrees enhance the clinical competence of a nurse-midwife, the ACNM believes that the requirement for a degree should not be in the law or in rules which have the force of law.\textsuperscript{134}
\end{quote}

Leaders in the field, such as Jo Anne Myers-Ciecko, Executive Director of the Seattle Midwifery School, feel that midwifery must be redefined depending on the country and culture where it is practiced. The Seattle School trains direct-entry midwives, and few of the students have had nursing training previously.\textsuperscript{135} In its philosophy, the school recognizes first, that the principles of normal birth are best learned in non-institutional settings, and second, that the best way to learn the art and science of midwifery is from experienced midwives. The School is known for its high standards of education. While Myers-Ciecko recognizes the importance of village midwives in Third World countries, she believes that "in the United States, where the population is highly mobile, culturally diverse, and generally relies on professionals for everything from food production to health care, more formal, explicit, and standardized requirements for entry into a service field involving life and death decisions are appropriate."\textsuperscript{136} The Seattle School program is based on the European three-year, direct-entry model in which the required

\textsuperscript{132} Baylor College of Medicine in Houston, Texas offers a fourteen-month program. Other certificate programs for nurses are offered in Kentucky, California, Pennsylvania, New York, and New Jersey. See Education Programs Accredited by the ACNM Division of Accreditation, 34 J. NURSE-MIDWIFERY 341 (1989).

\textsuperscript{133} Teresa Marsico, Testimony Before the American College of Obstetricians and Gynecologists, District II, New York State, on "The Future of Midwifery in New York State" (Dec. 11, 1990)(on file with author). Teresa Marsico, CNM, MEd, is Vice President of the American College of Nurse-Midwives.

\textsuperscript{134} Id.

\textsuperscript{135} Telephone Interview with Jo-Anne Myers-Ciecko (Jan. 14, 1992). See also SEATTLE MIDWIFERY SCHOOL, MIDWIFERY AND NURSE-MIDWIFERY EDUCATION CATALOG 3 (Oct. 1991).

\textsuperscript{136} Id.
nursing skills are built into the program.137 Like that of the American College of Nurse-Midwives, the educational philosophy of the Seattle Midwifery School is based on teaching the core competencies necessary to the entry-level practice of midwifery.138 Two schools similar to the Seattle School are expected to open in Florida in the fall of 1993.139

Ernest L. Boyer, President of The Carnegie Foundation for the Advancement of Teaching, and Senior Fellow of the Woodrow Wilson School at Princeton University, is responsible for instigating a meeting and collaborative effort of the American College of Nurse-Midwives (ACNM) and the Midwives Alliance of North America (MANA). Representatives of the ACNM and MANA have held several controversial meetings over the last few years. Boyer recently explained the reasons for his midwifery project: “In education, public policy isn’t just turned over to teachers to decide, yet for decades physicians have shaped the debate for health care. We should first look at the interests of mothers and babies.”140 According to Dr. Boyer, the time has come for midwifery in the United States to become an independent profession.141 He has proposed “a decade-long national crusade” describing midwives as “the [b]est [c]hoice.” Dr. Boyer wants the crusade to “tell the truth” about midwifery and describe vividly the impeccable credentials and the outstanding achievements of this profession.”

Conferees of Boyer’s program, who came from many backgrounds, agreed that multiple entry routes are required to increase the numbers of professional midwives.144 As direct-entry programs are approved, midwives hope to shape a core curriculum that will define clearly and coherently the fundamentals of the profession. As well as agreeing on a modern definition of a professional midwife, midwives have defined “core competencies” in which all midwives, regardless of the entry pattern, should be versed by the end of their training. The vice-president of the ACNM has noted that nurse-midwives and direct-entry midwives trained in comprehensive programs have very similar requirements:

[A] comparison of the ACNM core competencies for the practice of

138. See generally SEATTLE MIDWIFERY SCHOOL, supra note 135. The ACNM has recently authorized the Seattle Midwifery School to train nurse-midwives alongside the direct-entry students. Id.
139. Interview with Justine Clegg, Director, South Florida School of Midwifery (Dec. 4, 1992).
142. Id. at 218
143. Id.
nurse-midwifery and the statement of core competencies from the MANA midwifery educators' group [proponents of the direct-entry/non-nurse schools] resulted in almost complete agreement. Although the two documents were written differently, the essential content is the same.145

The collaboration of these two organizations has great potential for developing midwifery as a profession in the United States and making it available to many more thousands of American women. Even greater responsibilities for these broad-thinking midwives include bringing all types of midwives together and promoting midwifery as an independent and autonomous profession.146

A 1982 survey by the ACNM indicates that ninety-two percent of all nurse-midwives would like to provide services in birth centers or in the home. But by 1987, only fifteen percent of nurse-midwives worked in birth centers,147 and far fewer provided home birth services.148

III. A COMPARISON OF THE MEDICAL AND MIDWIFERY MODELS OF BIRTH

The two philosophies of childbirth—the medical model and the midwifery model—differ distinctively, as the following chart illustrates:

145. Marsico, supra note 133. The comparison was discussed at a summer 1990 meeting of a Seminar on Professional Midwifery Education sponsored by the Carnegie Foundation for the Advancement of Teaching. Id.

146. See Boston Women's Health Book Collective et al., Childbearing Policy Within a National Health Program: An Evolving Consensus for New Directions, at 16 (hereinafter Boston Collective) (unpublished manuscript on file with author). Significant differences remain. For example, factions differ as to the degree of their acceptance of physician supervision. In January 1978, the ACNM defined midwifery as the “independent management of . . . normal newborns and women . . . occurring within a health care system.” EDUCATION COMMITTEE, AMERICAN COLLEGE OF NURSE-MIDWIVES, CORE COMPETENCIES IN NURSE-MIDWIFERY app. 5 (1985). Nevertheless, the joint statement of the ACNM and the American College of Obstetricians and Gynecologists (ACOG) makes it clear that the ACNM nurse-midwives perceive their “manager” role as subordinate to the management of a physician:

The American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives believe that the appropriate practice of the certified nurse-midwife includes the participation and involvement of the obstetrician/gynecologist as mutually agreed upon in written medical guideline/protocols.

Id. This document requires the nurse-midwife to approach the obstetrician periodically to update the guidelines and protocols. It states that the interdependent practice of the two practitioners together “enhances the quality of care.” But the entity in control is clear. The midwife is allowed to provide care without the physical presence of the physician. The joint statement also identifies the nurse-midwife as part of the obstetrical team with the understanding that the obstetrician/gynecologist is the director. Id.

147. Rooks, supra note 144, at 35.

148. NAT'L CENTER FOR HEALTH STAT., supra note 32, at 7. Ina May Gaskin, an internationally known midwife from Tennessee, has been speaking out publicly for nurse-midwives around the country who feel sad and angry at the medical and political obstructions that prevent them from practicing their profession. Gaskin writes that “[o]ne would think that an education that can cost as much as $75,000 and maybe six years of your life ought to put you on a footing where you would not have to be under the thumb of another profession to practice yours.” Ina May Gaskin, Editorial, BIRTH GAZETTE, Spring 1992, at 2.
Pregnancy is normal. Pregnancy is a “condition.”

Pregnancy includes physical changes. Pregnancy causes “symptoms.”

The pregnancy is part of the woman. The pregnancy is “external” to the woman, not a part of her.

Pregnancy is a “working norm” for any woman. Pregnancy is “almost entirely a mechanical event” and is a stressor.149

Both before and after birth, the medical model conceives of the baby and the mother as conflicting entities with conflicting needs—the baby needs attention and feeding; the mother needs rest. In contrast, the midwifery model treats the needs of the mother and the needs of the infant as interlocking, during pregnancy and labor and after birth. The midwife interprets the mother’s need for “rest” as the need for relief from activities other than caring for her baby. The baby needs to be with the mother.150

A. The Medical Model

In the Netherlands, a doctor who wants to handle normal deliveries must study midwifery formally for one year.151 But U.S. medical schools do not consider midwifery training necessary for American doctors,152 who have little or no knowledge of the midwifery model of birth. Physicians in our country can graduate from medical school without having delivered a single baby. They can become board-certified in obstetrics and gynecology having never seen a normal birth conducted without interventions.153

In contrast, nurse-midwife and direct-entry midwife trainees manage a substantial number of births prior to certification or licensing. The ACNM does not mandate a minimum number of deliveries for a student nurse-midwife to manage during her educational experience,154 but some university-based
nurse-midwife programs require trainees to manage up to forty deliveries.\textsuperscript{155} Direct-entry trainees at the Seattle Midwifery School and in the Florida midwifery schools must manage fifty births prior to graduation.\textsuperscript{156} Midwife trainees in the European Community are required to manage forty normal births and assist with forty complicated births in order to graduate.\textsuperscript{157}

While midwifery can be described as primary care, obstetrical care is acute or tertiary care, developed specifically to treat genuinely pathological pregnancies and emergencies. Physicians determine the need for acute care by calculating the perceived risk; "the definition of risk is . . . central to the medical model of birth."\textsuperscript{158} In the calculation of risk approach, childbirth is seen and described as a life-threatening situation.\textsuperscript{159} This approach creates fear in the minds of the public, which then demands acute care.\textsuperscript{160}

Acute care, with its many interventions and drugs, ensures that the risk approach becomes a self-fulfilling prophecy.\textsuperscript{161} The infant mortality rate in the United States far exceeds that in Japan and Europe, where birth is considered normal and midwives are the attendant of choice. The following table provides infant mortality rates for many "First World" countries and shows how poorly the United States has done:

capacity to offer trainees the opportunity to manage twenty births during training. DIVISION OF ACCREDITATION, AMERICAN COLLEGE OF NURSE-MIDWIVES, CRITERIA FOR ACCREDITATION OF BASIC CERTIFICATE AND BASIC GRADUATE NURSE-MIDWIFERY EDUCATION PROGRAMS VII(C)(2)(c)(1988). This means a nurse-midwife can graduate after managing twenty or fewer births if she is deemed to have mastered certain core competencies.

\textsuperscript{155.} Letter from Frontier Nursing School to author (Dec. 8, 1992)(on file with author).
\textsuperscript{157.} Council Directive 80/155, supra note 9, at 11-12. Less experience with assisting birth has been related to higher mortality. See supra note 124.
\textsuperscript{158.} OAKLEY & HOUD, supra note 153, at 116.
\textsuperscript{159.} "Medicine must emphasize the diseaselike nature of pregnancy, its ‘riskiness,’ in order to justify medical management." ROTHMAN, supra note 23, at 156. "Normal pregnancy" then becomes an oxymoron within the framework of medical discourse. \textit{Id.} at 133. Although the physician may discuss pregnancy in terms of its being "normal and healthy," he or she will always place the patient in a "risk" category. A perfectly normal, healthy pregnant woman is classified as "low risk." The doctor at his or her discretion may label a woman’s pregnancy "high risk" due to her age or the number of children that she has borne previously. \textit{Id} at 132.
\textsuperscript{160.} It has been estimated that only three to five percent of pregnant women require obstetrical care. See supra text accompanying notes 29-30. This estimate, based on European data, differs from the estimates of American physicians. An American training text for obstetricians claims that medical intervention is required in ten percent of all cases. STEVEN L. CLARK, ET AL., CRITICAL CARE OBSTETRICS (2d ed. 1991).
\textsuperscript{161.} OAKLEY & HOUD, supra note 153, at 121.
INFANT MORTALITY RATE, 1989\textsuperscript{162}

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>NUMBER OF DEATHS PER 1000 LIVE BIRTHS</th>
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<tbody>
<tr>
<td>Japan</td>
<td>4.4</td>
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<tr>
<td>Finland</td>
<td>5.8</td>
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<tr>
<td>Sweden</td>
<td>6.0</td>
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<tr>
<td>Switzerland</td>
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<tr>
<td>Netherlands</td>
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<tr>
<td>Canada</td>
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<td>Hong Kong</td>
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<tr>
<td>France</td>
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<tr>
<td>Singapore</td>
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<td>German Federal Republic</td>
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<tr>
<td>Australia</td>
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<td>Norway</td>
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<td>Spain</td>
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<td>Austria</td>
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<td>Denmark</td>
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<td>England &amp; Wales (U.K.)</td>
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<td>Belgium</td>
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<td>United States</td>
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<td>Greece</td>
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</table>

Obstetricians do not provide primary care to the majority of the healthy pregnant women in any European country.\textsuperscript{163}

In a hospital birth, the mother’s efforts become a means for helping the \textit{doctor} deliver the baby.\textsuperscript{164} As soon as a pregnant woman enters the hospital, “active management of labor” by the obstetrician begins. The physician is the one who performs. He or she delivers the baby at the appropriate time, while the woman in labor is required to remain passive.\textsuperscript{165}

Expensive diagnostic tests are the rule rather than the exception for hospital births, even when the procedures have not been tested over the long term. An example of this is ultrasound scanning. The benefits of ultrasound have never


\textsuperscript{164.} \textit{Rothman}, supra note 23, at 249.

\textsuperscript{165.} \textit{Id.} at 34, 174.
been found to outweigh the potential risks to the fetus. Scientists theorize that routine ultrasound may cause fetal brain damage, visual and hearing impairment, chromosomal damage, or may result in childhood cancer. Studies to determine whether, in fact, these effects are occurring have been insufficient. The World Health Organization recommended against the regular use of ultrasound in 1984. Nevertheless, it has become routine. Traditional methods of assessment, however, usually work just as well as ultrasound scanning.

Obstetrical procedures have become standardized. Obstetricians rely on interventions and drugs extensively during the birth process. For example, the use of fetal heart monitors is now commonplace, although the advantages of using them are unclear. They often restrict a woman’s movements during labor. They have been related to increasing caesarean section rates and impersonal treatment. Electronic monitoring is no more accurate than the use of the traditional fetal stethoscope. Monitoring requires that the woman remain in the dorsal position. This places weight on blood vessels that carry oxygen to the fetus and thus possibly contributes to the distress that the monitor is designed to measure. In 1978, the National Center for Health Services Research (NCHSR) announced that “electronic fetal monitoring may do more harm than good” and expressed concern about the lack of medical evaluation before its introduction.

167. DONNISON, supra note 92, at 192.
168. ROTHMAN, supra note 23, at 47.
169. Although some monitors work by telemetry, allowing the woman to walk around, the most extensively used fetal heart monitor requires the woman to lie down during a time that she should be moving about and avoiding a recumbent position to facilitate the birth. See KITZINGER, supra note 52, at 26.
170. Id. at 25. Monitor print-outs often divert the attention of hospital staff from attending to the physical and emotional needs of the laboring woman.
171. ROTHMAN, supra note 23, at 47. Dr. Mendelsohn explains why electronic monitors may not be any more useful than traditional methods of monitoring the fetus:

> External fetal monitors consist of two bands that are strapped around your abdomen and connected to a monitoring unit that records the devices findings on tape. One band is pressure sensitive and records the strength and frequency of your contractions. The other employs ultrasound to determine the condition of the fetus. In most hospitals, doctors use fetal monitors routinely, although one study of 70,000 pregnancies found no difference in outcome between monitored and unmonitored patients, and other studies have shown that monitoring results in an increase in infant mortality among the patients monitored. This suggests that, at best, monitoring does no good, and at worst it may do harm.

ROBERT S. MENDELSON, HOW TO RAISE A HEALTHY CHILD IN SPITE OF YOUR DOCTOR 40 (1984).

172. DONNISON, supra note 92, at 192. The use of fetal monitors involves other risks as well. Both infant and mother are exposed to the risk of infection when the membranes of the sac surrounding the infant are ruptured. Artificial rupture of the membranes is required for inserting an electrode, by clip or screw, into the fetal scalp. Concerns have arisen that an H.I.V. positive mother may pass the infection to her baby when there is a laceration of the baby’s tissue. Letter from Sheila Kitzinger to author (Jan. 19, 1993)(on file with author).

173. ROTHMAN, supra note 23, at 45. The NCHSR report assessed the technique’s safety and cost effectiveness, and stated that the uncertain benefits and the known costs and risks do not seem to justify the technique’s widespread use. Id. at 46.
Similarly, researchers are beginning to be concerned that the use of drugs during labor may interfere with the ability of the infant to function after birth. Hospitals use a powerful synthetic hormone, Oxytocin (Pitocin, Syntocinon), to induce labor artificially or to stimulate contractions. Inducing birth with pitocin subjects the woman in labor to increased pain, and she consequently incurs greater risks to herself and the baby from analgesic (pain-relieving) drugs administered to decrease her discomfort. Induced birth has been shown to relate to longer retention of the placenta, post-partum hemorrhage, prolapse of the uterus, and post-partum depression. Induction is not normally necessary. Studies have shown that although a pregnancy prolonged after 42 weeks can affect perinatal outcome, induction of labor does not improve the baby’s chances of survival.

The medical model assumes that relieving pain is always a worthy goal. Until recently, demerol (meperidine) was the analgesic drug most frequently used during labor. Demerol is still used in some hospital obstetrical units, despite wording in the package insert explaining that the drug crosses the placenta and can depress the respiratory and psychophysiologic functions of the newborn. In a well-controlled investigation, John Morrison, an obstetrician at the University of Mississippi, found that one of every four infants of mothers who received only 50 milligrams of meperidine within one to three hours before delivery required resuscitation at birth. Stadol (butorphanol) and nubain (nalbuphine) are commonly used to control pain during labor today. The body eliminates stadol faster than demerol. Like demerol, however, both stadol and nubain have serious respiratory-depressant effects on the infant.

Epidural anesthesia is another highly acclaimed intervention; it allegedly allows a pain-free birth without interfering with the mental state. Hospitals use bupivacaine most frequently. Most or all sensation below the waist is removed by injecting the anesthetic at the mid-back, making it beneficial in caesarean sections and for difficult births. In normal birth, however, it deprives the mother of the ability to push her baby out and can easily complicate the labor.

Most obstetricians quietly agree that epidural block increases the

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174. Doris Haire, Drugs in Labor and Birth, CHILDBIRTH EDUCATOR, Spring 1987, at 1, 3, 7. When the FDA approves a drug for use, it does not mean that the agency guarantees the drug as safe for the fetus. It means only that the FDA has determined the benefits of the drug to outweigh its risks. Id. at 4.

175. DONNISON, supra note 92, at 193.

176. Tew, supra note 18, at 667 (citing Gibbs, supra note 26, citation omitted). Thus, uncomplicated post-maturity should not necessarily be considered an indication for induction.

177. Haire, supra note 174, at 5. Meperidine is frequently used along with a drug called promethazine (Phenergan). This drug relieves nausea and vomiting caused by powerful pain relievers such as meperidine, but is not without risk: “Research has shown that promethazine markedly impairs platelet aggregation in the fetus and newborn, a condition that can cause bleeding within the brain of the fetus without a similar effect in the mother.” Id. at 6.

178. MARTHA ANN AUVENSHINE & MARTHA GUNFTER ENRIQUEZ, COMPREHENSIVE MATERNITY NURSING: PERINATAL AND WOMEN’S HEALTH 389 (2d ed. 1990); Haire, supra note 174, at 6. Stadol is far more powerful than demerol and must be administered with extreme caution. Nubain has been found to concentrate more in the fetal circulation than in the mother’s. Id.

179. DONNISON, supra note 92, at 194.
rate of cesarean section. It is also associated with significantly longer labors, higher use of oxytocin, and more deliveries using forceps.

As the overuse of fetal monitors and drugs during labor and delivery illustrates, premature intervention can create a "snowball effect," requiring more and more interventions and increasing perinatal risks. The resulting iatrogenic or "doctor-caused" injuries result in extraordinarily high costs.

A recent Oxford University study found that doctors and hospitals often make the wrong decisions in treating pregnancy and labor, causing both medical and economic harm. Pointing out the dangers of the current system of obstetrics, the authors of the study noted that doctors are disease-oriented and that normal pregnancy, when treated like a disease, has a very poor outcome.

The current frequency and likelihood of malpractice litigation orients doctors toward preventing lawsuits; this orientation adversely affects women and babies. Induction of labor at or before forty-two weeks, for example, has become common to prevent the poor infant outcomes that are sometimes associated with the delivery of infants born post-term (beyond forty-two weeks gestation). But induction itself increases the likelihood of a caesarean section, which in turn increases the risks to both mother and infant. "Caesarean delivery is associated with much higher maternal morbidity and mortality rates than vaginal delivery." Ironically, liability may actually increase due to induction of labor, which clearly has the potential to backfire as a means of avoiding liability.

Most women who deliver in the hospital will experience a surgical technique. If they do not experience episiotomy, they are likely to deliver via caesarean section. Four obstetrical procedures—caesarean sections, episiotomy, repair of obstetric lacerations, and artificial rupture of membranes—accounted for eighteen percent of all surgical procedures.
Diagnostic ultrasound comprised ten percent of all nonsurgical procedures, while fetal EKG and fetal monitoring accounted for eight percent. Episiotomies were performed routinely in the United States by the 1950s, and even today are very common in spite of research showing the assumptions underlying the routine practice to be unjustified. The surgical incision heals no more easily than a natural tear and does nothing to insure a healthy baby in an uncomplicated delivery. In 1976, the first empirical study to determine the long-term effectiveness of episiotomies found that they were associated with prolapsed uteri, tears in the vaginal wall, and sagging perineums. They were previously believed to prevent these conditions. Episiotomies, however, continue to be performed to facilitate stitching after the birth since repairing a tear can be more time-consuming. Whether an episiotomy is “necessary” is often left to the discretion of the doctor. In 1990, episiotomies were being performed at the rate of 55.8 per 100 vaginal deliveries.

During labor, if the obstetrician decides that the woman is “failing to progress,” there is a high likelihood that she will undergo a caesarean section. One out of every four women who are in labor in hospitals is taken for major obstetrical surgery. Physicians’ rationale for this statistic is that operative deliveries “minimize the risk of injury, disease or death for mother and child.” In fact, delivery by caesarean section carries a greater risk of illness and death for the mother, and perhaps for the infant as well. The risk of death to the mother alone is two to four times that associated with vaginal birth.

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189. NAT'L CENTER FOR HEALTH STAT., U.S. DEPT. OF HEALTH AND HUMAN SERVS., VITAL AND HEALTH STATISTICS, DISCHARGE SURVEY: ANNUAL SUMMARY 1990 (June 1992). Episiotomy is the cutting of the perineum to enlarge the vaginal opening.
190. Id. at 9.
191. DONNISON, supra note 92, at 193.
193. ROTTMAN, supra note 23, at 58.
194. DONNISON, supra note 92, at 194.
195. NATIONAL CTR. FOR HEALTH STATISTICS, supra note 189, at 9.
196. Wagner, supra note 68, at 479. See generally LYNN SILVER & SIDNEY WOLFE, UNNECESSARY CESAREAN SECTIONS: HOW TO CURE A NATIONAL EPIDEMIC (1989). Caesarean sections are far more profitable than vaginal deliveries for both hospitals and physicians. The average fee in the United States for a vaginal delivery in 1989 was $4334 ($1492 for physician; $2842 for hospital) while the fee for a caesarean section averaged $7186 ($2053 for physician; $5133 for hospital). VAN TUiNEN & WOLFE, supra note 33, at 39.
197. See supra text accompanying note 187 (maternal risks). “The maternal mortality rate from sections is one per 2,000 as compared to the maternal mortality rate from vaginal births which is one to 50,000.” Mendelsohn, NAPSAC Address, supra note 188. “[C]aesarean sections have no advantage for infants and may indeed cause harm. . . . While [they] may protect extremely large infants . . . from trauma, small infants in breech position, or infants with other abnormal positions in the uterus, for most other groups, no advantage has been demonstrated. . . . [Infants up to 8 lb. 6 oz.] in breech position can be delivered with near equal safety by either route, although this area is still controversial.” SILVER & WOLFE, supra note 196, at 14. There is no evidence that the performance of unnecessary caesarean sections lessens the legal risk for an obstetrician. See id. at 24.
198. SILVER & WOLFE, supra note 196, at 12; see also Valerie Bhatta, University Doctors Hold Line On Cesareans, FLORIDA TIMES UNION, Nov. 25, 1990, at B1.
Caesarean sections are also associated with a risk of abnormal blood clotting, injuries to the surrounding organs, higher rates of infertility, and much slower recoveries after the birth. Caesarean-born babies are at a greater risk for low birth-weight, premature birth, and birth injuries than those born vaginally. The overuse of caesarean sections also adversely affects the skill of obstetricians, depriving them of experience in delivering babies vaginally in complicated cases. Rather than risk potential problems of vaginal delivery, obstetricians often opt for the caesarean section as an easy way out.

Errors by doctors in the timing of elective caesarean sections contribute to respiratory distress syndrome (RDS), a condition caused by immaturity of the lungs that can lead to fetal death. One study found that one out of every eight caesarean sections results in RDS, the most common complication of caesarean sections. RDS is also one of the major factors associated with Sudden Infant Death Syndrome (SIDS). Despite the obvious fact that avoiding unnecessary caesareans is the most effective means of avoiding physician-caused prematurity and RDS, a recent study at Oxford suggests that more than fifty percent of the caesarean sections performed in United States hospitals today are unnecessary.

There are other costs associated with the overuse of caesareans. Normal-sized babies delivered by caesarean section frequently have lower Apgar scores than babies delivered vaginally. The increased use of caesarean sections does not contribute to a reduction in infant mortality. Moreover, women who have caesareans must be hospitalized twice as long as those who deliver vaginally. Thus, the incredibly high rate of caesareans in the United States results in awesome human and financial costs. In 1988, the national caesarean section rate skyrocketed to 24.7%, from 5.5% in 1970. By 1990, of the 2.83 million live births, 23.5% were caesarean sections. Yet, rates higher

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199. SILVER & WOLFE, supra note 196, at 13.
200. Korte, supra note 4, at 85.
201. DONNISON, supra note 92, at 194.
202. Hiam, supra note 63, at 40. There is no evidence that the performance of unnecessary caesarean sections lessens the legal risk for obstetricians. See SILVER & WOLFE, supra note 196, at 24. In recent years, in fact, women have filed a number of lawsuits against obstetricians for performing unnecessary caesareans. Id. Of course, the high number of lawsuits increases malpractice insurance rates, the cost of which is passed along to the consumer.
205. SILVER & WOLFE, supra note 196, at 14.
206. Ubell, supra note 184, at 11.
207. Richard D. Burt, Evaluating the Risks of Cesarean Section: Low Apgar Score in Repeat C-Section and Vaginal Deliveries, 78 AM. J. PUB. HEALTH 1312, 1313 (1988). Apgar scores are an index of the well-being of the baby immediately after the birth, in which low scores are a sign of abnormal function.
208. Wagner, supra note 68, at 479-80.
210. VAN TUINEN & WOLFE, supra note 33, at 1.
211. Id. at 3.
than ten to fifteen percent are unjustifiable.212 For example, in the United States, the estimated cost of unnecessary caesarean sections for 1986 was just under two billion dollars.213 In the mid-1980s, doctors estimated that when the caesarean section rate increases by just one percent, U.S. hospital costs go up by over $54 million.214

It is notable that countries with some of the lowest perinatal mortality rates in the world have caesarean section rates of ten percent or less.215 The following chart compares caesarean section rates for various countries:

### CAESAREAN SECTION RATES216

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>Number of Caesarean Sections per 100 Births</th>
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<tbody>
<tr>
<td>Czechoslovakia</td>
<td>7</td>
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<tr>
<td>Japan</td>
<td>7</td>
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<tr>
<td>Hungary</td>
<td>10</td>
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<tr>
<td>Netherlands</td>
<td>10</td>
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<tr>
<td>England and Wales (U.K.)</td>
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<td>New Zealand</td>
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<tr>
<td>Switzerland</td>
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<td>Norway</td>
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<td>Spain</td>
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<td>Puerto Rico</td>
<td>29</td>
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<tr>
<td>Brazil</td>
<td>32</td>
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212. Id. at i.
213. Wagner, supra note 68, at 479-80.
215. Id. at 3.
Studies have found that women beginning labor under the care of midwives experienced well under half the number of caesarean sections than carefully matched women receiving care from obstetricians.217

Our high-tech society has not yet realized that there are limits to the desirability of technology, especially with regard to its impact on a natural event like birth.218 Between 1984 and 1987, the number of obstetrical procedures increased enormously. Use of diagnostic ultrasound increased by 350%; vacuum extraction increased 132%; manually assisted delivery increased 300%; fetal monitoring increased 427%; artificial rupture of membranes increased 107%; medical induction of labor increased by 162%; repair of obstetrical lacerations increased by 39%; and caesarean sections increased 16%.219 Almost all of these interventions—many of which were unnecessary—occurred in the hospital. The interventions make hospital birth far less safe than our technology-loving society would expect.220

The need for maternity services by well-trained providers is escalating, especially in rural areas. In 1987, a survey of members of the American College of Obstetricians and Gynecologists (ACOG) found that forty-one percent of them had limited their obstetric practice, and twelve percent were no longer accepting pregnant patients.221 Many specialists have stopped delivering babies because of the high cost of malpractice insurance.222 Moreover, obstetricians providing care are extraordinarily busy. The short amount of time that obstetricians spend with their patients has been proven unsatisfactory to many women, and significantly deters communication. Some patients also dislike authoritarian physician mannerisms.223 Obstetricians have notoriously “poor doctor-patient relationship[s]” in the obstetrician’s office and the hospital delivery room.224 A 1981 study found that nurse-midwives spend

217. Anne Scupholme et al., A Birth Center Affiliated With the Tertiary Care Center: Comparison of Outcome, 67 OBSTETRICS & GYNECOLOGY 598, 601 (1986) (fifty-seven percent fewer); Gigliola Baruffi et al., A Study of Pregnancy Outcome in a Maternity Center and a Tertiary Care Hospital, 74 Am. J. PUB. HEALTH 973, 976-77 (1984) (seventy-one percent fewer).

218. See Marsden Wagner, Is Homebirth Dangerous?, THE BIRTH GAZETTE, Fall 1989, at 16-17. Wagner writes about Europe, but the theory is applicable to the United States. “There is, in fact,” Wagner says, “no good scientific evidence that homebirth (or birth in a small birth clinic) is more dangerous than hospital birth . . . .” Id. at 16. Statistics indicating that as hospital births increase, overall mortality decreases are misleading. They are due, Wagner points out, to the fact that currently, most out-of-hospital births are unplanned and accidental; most of these births are premature, and thus, have a high infant mortality rate. Id. Wagner calls for a more scientific investigation of mortality associated with planned homebirths versus that associated with hospital births. Id. at 16-17.


220. In fact, studies suggest that reduced use of technology increases benefits to women because they avoid the risks, discomfort, and disruption imposed by these procedures. Boston Collective, supra note 146, at 12.

221. Rooks, supra note 52, at 31.


223. Id. at 24.

an average of twenty-four minutes per visit with their clients. In contrast, a 1975 study found that prenatal care office visits with a physician lasted ten minutes, and thirty-two percent of obstetrician visits lasted five minutes or less.225 One recent study compared the satisfaction levels of women with midwives and obstetricians as primary-care providers: eighty-eight percent of midwife clients were "very satisfied," as compared with only forty-five percent of obstetrician patients.226

B. Midwifery Model

Midwifery is indispensable and an essential part of good obstetrical organization, since midwifery means: protection of health and normality, whereas obstetrics, as part of medicine, belongs to the "department of knowledge and practice, dealing with disease and its treatment" . . . To care for pregnancy and childbirth, you need a midwife and a doctor. I hope that they will . . . respect and admire one another and will know that they are both needed and complementary.227

All the European countries with perinatal and infant mortality rates lower than that of the United States use midwives as the sole birth attendant for at least seventy percent of all births.228 In Japan, the country with the lowest infant mortality rate in the world, midwives are the primary birth attendants.229 Researchers agree that countries that rely heavily on professionally trained midwives consistently have the lowest infant mortality and the lowest birth trauma rates.230 In order to improve its perinatal mortality rate and the health status of women and infants, the United States should emulate policies in countries that have lower infant mortality rates.

Programs to decrease poverty, provide good nutrition, and offer social support are the most effective, cost-saving ways to avoid poor outcomes of pregnancy and improve infant health.231 Traditional prenatal care alone is not enough.232 Midwifery is socially oriented preventive care, which incorporates prenatal care and a concern for the social and emotional aspects of pregnancy and birth in order to meet the individual needs of each

225. Rooks, supra note 52, at 32.
226. OAKLEY & HOUD, supra note 153, at 55 (describing study by H.B. Perry, citation omitted).
228. Wagner, supra note 68, at 481.
229. Korte, supra note 4, at 86.
230. See ROTHMAN, supra note 23, at 42; Kloosterman, supra note 14, at 9; Wagner, supra note 218, at 16.
231. See Wagner, supra note 68, at 481-83. OAKLEY & HOUD, supra note 153, at 100. See also ANN OAKLEY, THE CAPTURED WOMB: A HISTORY OF THE MEDICAL CARE OF PREGNANT WOMEN 75 (1984); C. Arden Miller, Infant Mortality, MOTHERING, Summer 1988, at 62, 64; Page, supra note 66, at 255.
232. Wagner, supra note 68, at 473.
woman. Midwifery presumes that childbirth is a healthy and normal event. A holistic approach in which the mind and body are mutually important to the outcome, midwifery recognizes that in childbirth, mind and body cannot be separated: "A woman’s body works best when she feels confident, secure, emotionally supported, and on her own ground."

Midwives focus on providing primary maternity care rather than on what can go wrong in the pregnancy. Primary care involves education, health promotion, nutritional screening and counseling, and social support, as well as clinical assessment. Midwives do the same kind of screening as physicians during prenatal visits, but they have a broader emphasis and spend more time with each woman. Midwives encourage self-help and personal responsibility as goals for each woman. The midwife spends time teaching in order to remove the mystique surrounding pregnancy and to empower the client. She teaches the woman or couple that pregnancy is a time for "psychological as well as physical growth and development." In comparison with obstetrical care, this type of personalized prenatal care results in better client participation and satisfaction.

After a midwife determines that the pregnancy is normal, she becomes familiar with her clients’ lives in order to inform the woman or couple of the available options regarding the setting and type of birth. The care is woman-centered and, since the fetus is thought of as part of its mother, midwives assume its needs are met when the mother’s needs are met.

Midwives believe that the birthing woman has a right to responsibility over her own body, her baby, and her birth. At the birth the midwife “catches” the baby; she does not “deliver” it. She assists the laboring mother; she does not control her. Midwives let nature take its course, intervening only when clearly necessary. Intervention or “doing something” to the woman to try to

233. Page, supra note 66, at 257.
234. ROTHMAN, supra note 23, at 35.
235. KITZINGER, supra note 52, at 25. Dr. Michel Odent explains that the nervous system and the endocrine system are inextricably linked. According to Odent, new research indicates that the neo-cortex of the brain regulates hormones that control the process of birth. This is why privacy in a familiar environment at the time of birth positively influences the process of labor. Michel Odent, Birth and Beyond 64-66 (Mar. 1993)(unpublished anthology distributed on 1993 U.S. Speaking Tour, on file with author)(excerpts from 1989 article: Dr. Michel Odent, What is Health? Towards an Ontogenic Definition, 1989 INT. J. PRENATAL & PERINATAL STUDIES 47).
236. See Boston Collective, supra note 146, at 9.
237. ROTHMAN, supra note 23, at 160.
238. Midwifery care gets high marks in communication. A 1985 U.S. Office of Technology Assessment study revealed that care provided by midwives was characterized by better communication and counseling skills than those provided by doctors. OAKLEY & HOUD, supra note 153, at 55. Subsequent to the delivery, all of the women in this study who had been attended by midwives said that they would not have preferred a doctor for the delivery. Some of the women who had been delivered by doctors felt afterward that they would have preferred midwifery care. Id.
239. If the pregnancy is abnormal, the midwife refers the pregnant woman to an obstetrician.
240. ROTHMAN, supra note 23, at 161.
241. Id. at 155.
242. Id. at 225.
push the progress of the labor is avoided for as long as possible.\textsuperscript{243} The midwifery model of birth has no strict time limits. Each woman's labor and delivery is seen as unique.\textsuperscript{244} Skilled midwives claim that the biggest lesson they've had to learn is to "sit on [their] hands and not do anything."\textsuperscript{245}

Midwives recommend benign methods to stimulate labor when a woman's pregnancy approaches the "post-mature" stage. Enemas, nipple stimulation, or sexual intercourse sometimes work as well or better than drugs.\textsuperscript{246} The woman is sent to the hospital for induction only if these measures are ineffective.

In a midwife-attended home or birth-center birth, the woman is not required to lie down. She is not "attached" to the bed and has no IV poles or monitors attached to her.\textsuperscript{247} She can get up and walk to the bathroom in privacy and is encouraged to empty her bladder frequently during labor.\textsuperscript{248} She can eat in the first stage of labor, and is offered drinks frequently.\textsuperscript{249} Vaginal exams are done periodically, but not on a rigid schedule as in hospitals. The laboring woman's support person may be intimately involved, massaging or lying in bed with her.\textsuperscript{250}

Experienced midwives usually recognize that the psychological condition or comfort of the woman may cause her labor to start and stop. This frequently occurs when a laboring woman enters a hospital for childbirth. Her contractions, though strong and regular on entry, may become weak and spasmodic.\textsuperscript{251} If a woman is worried while she labors, she may stop having contractions until her concern is resolved.\textsuperscript{252} For this reason, home birth may be ineffective for some women. A woman who thinks that hospital birth is safer than out-of-hospital birth may stop having contractions until she is hospitalized.\textsuperscript{253}

During the second stage of labor, from full dilatation of the cervix through the birth, the woman is wide open, usually not in acute pain, but anxious not to be moved.\textsuperscript{254} As she enters the second stage, she may experience an uncomfortable low backache and a drop in morale. The midwife empowers

\textsuperscript{243} Id. at 262.
\textsuperscript{244} Id. at 261.
\textsuperscript{245} DEBORAH A. SULLIVAN & ROSE WEITZ, LABOR PAINS 71 (1988).
\textsuperscript{247} ROTHMAN, supra note 23, at 236.
\textsuperscript{248} Id. at 237.
\textsuperscript{249} Id. at 238.
\textsuperscript{250} KITZINGER, supra note 52, at 142.
\textsuperscript{251} Id. at 252.
\textsuperscript{252} Id. at 252.
\textsuperscript{253} In the hospital a laboring woman cannot have food or drinks. She is prepared for anesthesia, even for a planned "natural" birth. Id.
the laboring woman with encouragement, sincerity, and understanding.\textsuperscript{255}
To be certain that the baby is experiencing no distress, the midwife uses a special stethoscope to keep track of its heart rate.

At “transition,” when the woman’s cervix is fully dilated, the midwife helps her into positions that facilitate the downward movement of the baby. At this point, most women feel a strong urge to push the baby out. Some women may deliver without any deliberate pushing. The actual length of time and amount of work required to deliver the baby differs with each woman.\textsuperscript{256}

In the medical model, the second stage of labor currently lasts fifty minutes.\textsuperscript{257} Once labor starts, it cannot stop and start again and still be considered “normal.” Any pause in labor triggers medical intervention. In the home or birth-center environment, the midwife understands that the second stage may last up to three or occasionally four hours.\textsuperscript{258} When the baby’s head is emerging or “crowning,” the midwife often exerts gentle pressure to guide it out slowly and carefully without damage to the perineum. Experienced midwives deliver breech babies and large babies without tears by repositioning the woman to facilitate the birth. Shoulder dystocia or “stuck shoulders,” frequently a side effect of drug-induced labor, is common in hospitals but rarely occurs in home birth.\textsuperscript{259}

Episiotomy is not routine in home birth. When they are necessary, midwife episiotomies are generally much smaller incisions than physician-performed episiotomies.\textsuperscript{260} When the baby emerges, it is immediately placed in its mother’s arms. Midwives often clean and diaper the baby for the mother. Then, if necessary, the midwife administers local anesthesia and repairs the perineum.\textsuperscript{261}

Most American midwives observe the respiratory status of the infant and record an Apgar score. Babies whose mothers were undrugged during labor usually breathe spontaneously. For the rare exception, the midwife uses portable resuscitation equipment that she carries to each birth.\textsuperscript{262}

If the third stage, the expulsion of the placenta, takes longer than twenty minutes, the midwife suggests noninterventive techniques such as breast

\begin{footnotes}
\footnote{255. KITZINGER, supra note 52, at 143-48.}
\footnote{256. Id. at 150-52.}
\footnote{257. PRITCHARD ET AL., supra note 22, at 337. The natural length of labor is of course physiologically determined, but in the medical model it is subject to medical control. See supra notes 22-24 and accompanying text (describing the changes over time of what physicians describe as the “normal” length of labor). In only three decades, physicians determined that there was “a need” to shorten what was considered “normal.” ROTHMAN, supra note 23, at 263.}
\footnote{258. But the midwife must “look good” on paper and, for the safe delivery of the woman, may not list the beginning of the second stage as soon as a hospital nurse might. Cervical dilatation is an “objective” measure but competent birth attendants may disagree on when it starts. The midwife gives the mother the benefit of the doubt by not calling it “second stage” until all of the cervical rim is out of the way of the emerging baby. ROTHMAN, supra note 23, at 266, 267.}
\footnote{259. KITZINGER, supra note 52, at 156.}
\footnote{260. ROTHMAN, supra note 23, at 240.}
\footnote{261. Id. at 243.}
\footnote{262. KITZINGER, supra note 52, at 159.}
\end{footnotes}
stimulation. Breastfeeding the baby may help expedite expulsion by stimulating contractions of the uterus. The midwife monitors the woman for excessive bleeding during this period, prepared to arrange a safe transfer should measures within her scope of practice prove ineffective.\textsuperscript{263}

After the mother and child are clean, safe, and comfortable, the midwife offers counseling and support and makes an appointment to see them both the following day. She often makes home visits for up to six weeks after the birth. According to Sheila Kitzinger,

A carefully planned and lovingly conducted home birth, in which the rhythms of nature are respected and the woman is nurtured by attendants who have the knowledge and understanding to support the spontaneous unfolding of life, is the safest kind of birth there is, and the most satisfying for everyone involved.\textsuperscript{264}

Although obstetricians and family practice physicians sometimes do provide midwifery service as identified by the midwifery model, the limits of medical education and practice coupled with fear of punishment by colleagues for not following obstetric specialist standards make physician-provided midwifery services rare.\textsuperscript{265}

IV. MIDWIFERY AND PUBLIC POLICY: FACTS, CRISES, SOLUTIONS

Legislators and other policy makers in the United States, under the influence of medical lobbyists, frequently treat birth as an event requiring the mechanisms of acute medical care. Many states continue to restrict the practice of midwifery to medically trained nurses. The prospects for judicial reform of the medical hegemony over childbirth are dimming. A 1977 California case and a recent Illinois case both suggest that courts are unwilling to entertain arguments about constitutional issues surrounding the practice of midwifery.\textsuperscript{266} Arguments about both the individual woman’s privacy right to choose the circumstances of her delivery and the due process right of midwives to practice their profession have failed in the judicial arena.

At the same time, evidence suggesting that midwives and obstetricians are both necessary to a working system of care—that they are “not interchangeable as providers of care”\textsuperscript{267}—continues to gain prominence in the health care field worldwide. The media have focused on the national crisis in obstetric

\textsuperscript{263} In emergencies, midwives administer a life-saving drug by intermuscular injection that stops the bleeding. \textit{Id.} at 160-62.

\textsuperscript{264} \textit{Id.} at 163.

\textsuperscript{265} Boston Collective, \textit{supra} note 146, at 9.

\textsuperscript{266} Peckmann v. Thompson, 745 F. Supp. 1388 (C.D. Ill. 1990); Bowman v. Municipal Ct., 556 P.2d 1081 (Cal. 1977). See \textit{infra} notes 291-99 and accompanying text for a discussion of these cases.

\textsuperscript{267} OAKLEY & HOU D, \textit{supra} note 153, at 15.
care, but have regularly ignored midwives.268 It is time for legislators and other policy makers, as well as the national media, to recognize the advantages of midwifery.

**A. Evidence Regulators Should Consider**

A 1991 article in the Journal of the American Medical Association stated that “the continuous presence of a supportive female companion during labor and delivery could significantly reduce the need for Caesarean section.”269 According to the authors, studies in Guatemala had shown that not only did women with a female companion experience far fewer c-sections, they required “fewer obstetrical interventions, [had] shorter labors, and [experienced] fewer perinatal problems [with] the fetuses and the neonates.”270 The implications for the quality and cost of perinatal care, were said to be “highly significant.” The challenge, the doctors said, is to “turn to obstetric technology only when necessary, relying instead on the practice of continuous labor support to help the birth process follow its natural, normal course.”271

In a speech to the U.S. Commission to Prevent Infant Mortality, Marsden Wagner, regional director of the World Health Organization in Europe, charged that the United States’ focus on medical care as an answer to high infant mortality has never been effective.272 Instead, he recommended that the United States spend less money on medically oriented prenatal care and interventionist obstetrical care, and devote more resources to developing a strong, independent midwifery profession.273

British statistician Marjorie Tew demonstrated that “high technology can rarely make birth safer, whether the predicted risk is high or low.”274 Tew’s scientific analysis of thousands of births in Holland revealed that after thirty-two weeks gestation, the perinatal mortality rate was far lower when the mothers were under the care of midwives than when obstetricians were the primary caregivers.275 For premature babies, midwives had similar outcome statistics to those of physicians; the chance of survival for these very small babies was about the same regardless of attendant or place of delivery.276

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268. Boyer, supra note 141, at 218.
270. Id.
271. Id. at 2201.
272. Wagner, supra note 68, at 473.
273. Id. at 474-84.
276. Id. Other recent journal articles have further substantiated the safety of midwife-attended birth. A 1990 article in the Journal of the American Medical Association reported that a system of care utilizing independent midwives was “feasible” and “worthy of consideration.” Pieter Treffers, Home Births and Minimal Medical Interventions, 264 J. AM. MED. ASS’N 2203, 2208 (1990). The study took place in the
Studies aimed at proving the hypothesis that midwife-attended home birth is dangerous, on the other hand, are old and unreliable. The most commonly used "study" was published by the American College of Obstetricians and Gynecologists in the 1970s.277 The study claimed that "out-of-hospital births pose a two to five times greater risk to a baby's life." But the cited study lumped miscarriages, premature births, taxi cab deliveries, and other unplanned precipitous births together with out-of-hospital births that were planned and attended by trained midwives.278

A true scientific study, however, was performed at about the same time. The 1970 Mehl study matched 1046 women who were planning home birth with 1046 women who were planning hospital birth for age, social parity, socioeconomic status, and risk factors. All outcomes in the home birth cases that had to be transferred to hospitals were attributed to home birth. The results of the study were remarkable:

- The hospital births had five times the incidence of maternal high blood pressure (possibly an indication of greater physical and emotional stress);
- The hospital births had three and one-half times the amount of meconium staining (fetal bowel movement expelled into the amniotic fluid, indicative of fetal distress);
- The hospital births had eight times the shoulder dystocia (the fetal shoulder getting caught after the head is born; midwives handle this by turning the woman to hands and knees position which is still not frequently used in the hospital);

Netherlands, where over one-third of all births occur at home, and one-third are supervised in the hospital by a midwife who is not under the control of an obstetrician. Odent, supra note 235, at 19.

A different study of 1001 midwife-attended home births in Toronto that occurred between 1983 and 1988 found only one neonatal mortality, with only 3.4% of births requiring Caesarean sections. Holliday Tyson, Outcomes of 1001 Midwife-attended Home Births in Toronto, 1983-1988, 18 BIRTH 14 (1991). ("Neonatal" mortality refers to deaths that occurred from birth up to 28 days of life.)

In yet another study, 1,707 home births attended by apprentice-trained midwives in a Tennessee community were examined. The author concluded that home birth with non-nurse midwives can be as safe as conventional hospital delivery for low-risk pregnancies. A. Mark Durand, The Safety of Home Birth: The Farm Study, 82 AM. J. PUB. HEALTH 450 (1992).

In 1989, the New England Journal of Medicine reported birth outcomes for 11,814 women with nurse-midwives as the primary attendants. The neonatal mortality rate was 1.3 per 1000 births, and only 4.4% of the women had Caesarean sections. The authors concluded that birth centers offer a safe and acceptable alternative to hospitals for normal pregnancies. Rooks et al., supra note 52, at 1804.

277. American College of Obstetricians & Gynecologists, Health Department Data Shows Danger of Home Births (Jan. 4, 1978)(press release announcing results of study) [hereinafter ACOG Press Release]. The medical lobby used results from this study during the 1991 Florida legislative session to "prove" the dangers of home birth so that the bill to allow training schools for direct-entry midwives would fail. See Letter from Amy J. Young, lobbyist for Florida Medical Association and Florida Obstetric and Gynecologic Society, to members of Florida Senate (Mar. 29, 1991)(on file with author).

278. Sociologist Raymond DeVries points out that the study was misleading as well as unscientific. DeVRIES, supra note 39, at 134. In one paragraph of its press release, the ACOG claimed it had "received reports" from forty-seven states, but in another paragraph it said that its data was culled from reports from eleven state health departments. ACOG Press Release, supra note 277, at 1; see also DEVRIES, supra note 39, at 134.
The infant deaths, both perinatal (during birth) and neonatal (after birth) were essentially the same for the two groups; Apgar scores (indicative of the condition of the baby) were better for the home birth babies (though caregivers in either setting may introduce biases into these readings); More than three times as many babies in the hospital required resuscitation; Four times as many hospital babies became infected; Thirty times as many hospital babies suffered birth injuries (attributable to forceps); Fewer than five percent of the home-birth women received analgesics or anesthesia, while seventy-five percent of the women in the hospital group were administered such drugs; Caesarean sections were three times more frequent in the hospital group; Nine times as many episiotomies were performed in the hospital group and nine times as many severe (third- and fourth-degree) tears occurred in the hospital group.279

B. Existing Statutes and Regulations

Despite the convincing evidence in support of midwifery, state laws differ radically regarding licensing and practice requirements. Nineteen states and the District of Columbia place legal prohibitions on midwifery and only allow its practice by nurse-midwives. In four states—Maryland, Ohio, West Virginia, and Wisconsin—midwifery is statutorily defined as a function of nursing, so practice by non-nurse midwives is illegal.280 Midwifery (except for nurse-midwifery) is prohibited in Illinois, Nebraska, and the District of Columbia because it is defined by statute as “the practice of medicine.”281 Statutes require midwives to be certified nurse-midwives in five states: Hawaii, Indiana, New York, North Carolina, and Virginia.282 In seven other states—Alabama, Delaware, Georgia, Kentucky, New Jersey, Pennsylvania and Rhode Island—only nurse-midwives may practice, because licensing is performed by medical authorities.283 Direct-entry and lay midwives do not

practice in Iowa because in 1978 the state Attorney General defined midwifery as "practicing medicine without a license."284

Colorado, Florida, Louisiana, Montana, Texas, and Washington have elaborate statutes governing the practice of direct entry midwives; a bill passed by the California General Assembly governing the practice of direct-entry midwives is expected to be signed into law.285 In nine states—Alaska, Arizona, Arkansas, Minnesota, Missouri, New Hampshire, New Mexico, Oregon, and South Carolina—statutes allow midwives to practice under the authority of state agencies.286 Sixteen states have no specific regulatory statute. In ten of these states—Connecticut, Idaho, Kansas, Maine, North Dakota, Oklahoma, South Dakota, Tennessee, Vermont, and Wyoming—"the practice of medicine" is defined narrowly, limiting its scope to the treatment of abnormal conditions.287 In Mississippi, midwifery is defined as part of the

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285. COLO. REV. STAT. §§ 12-36-106 (1)(f), 12-37-101 et seq. (providing for licensing of direct entry midwives who have passed an examination designed by an independent organization with authority on the practice of midwifery); FLA. STAT. ch. 467.002-209 (1992) (providing for departmental approval of three-year midwifery programs in the state and requiring clients of direct entry midwives to see a physician twice during the pregnancy); LA. REV. STAT. ANN. §§ 37:3240-3248 (West 1988) (establishing licensure by the State Board of Medical Examiners); MONT. CODE ANN. §§ 37-3-103(1)(p), 37-27-101 et seq. (1991) (specifically exempting direct-entry midwifery from medical practice, statutorily recognizing the right of Montanans to give birth where and with whom they choose, and providing a "Direct-Entry Midwifery Licensing Act" where midwives must advise clients to consult with a physician or CNM twice during the pregnancy); TEX. HEALTH & SAFETY CODE ANN. § 4512i (West Supp. 1993) (establishing a midwifery board reporting to the Texas Board of Health and requiring disclosure by midwives of their credentials to clients); WASH. REV. CODE ANN. § 18.50 et seq. (West 1989) (providing protocols and autonomy for direct entry midwives). On September 9, 1993, the California General Assembly passed a bill that requires the Medical Board of California to issue licenses to direct entry midwives qualified as provided in the law. S.B. 350, Calif. 1993-94 Regular Sess. At the time of publication of this article, the bill had not yet been signed into law.

For a survey of the fifty states' regulation of lay midwifery as of March 1, 1986, see Charles Wolfson, MIDWIFERY AND HOME BIRTH: SOCIAL, MEDICAL, AND LEGAL PERSPECTIVES, 37 HASTINGS L.J. 909, 957-67 (1986). Wolfson also offers a model statute allowing lay midwifery and homebirth. Id. at 968-76.

286. ALASKA STAT. § 18.05.040 (1991) (providing that lay midwifery be regulated by Dept. of Health and Social Services); ARIZ. REV. STAT. ANN. § 36-755 (Supp. 1992) (providing that Department of Public Health and Services define "the duties and limitations of the practice of midwifery"); ARK. CODE ANN. § 17-85-102 (Michie 1992) (requiring that State Board of Health license lay midwives); MINN. STAT. ANN. § 148.31 (West Supp. 1993) (requiring that midwives be licensed by the state board of medical practice); MO. ANN. STAT. § 334.120 (Vernon 1989) (providing that midwives be licensed by the State Board of Registration for the Healing Arts); N.H. REV. STAT. ANN § 326-D:2-4 (1984) (requiring the Department of Public Health Services to use information from "advisory committee for the practice of lay midwifery" to establish midwifery qualifications and a midwifery certification process); N.M. STAT. ANN. §§ 24-1-3 R. (Michie 1992) (requiring that the health services division of the health and environment department regulate midwifery); 1993 OR. LAWS ch. 362 (authorizing Office of Medical Assistance Programs to certify direct-entry midwives; S.C. CODE ANN. § 44-89-30 (Law Co-op. Supp. 1991) (requiring that the Department of Health and Environmental Control license midwives).

287. CONN. GEN. STAT. § 20-9 (1991); IDAHO CODE § 54-1803 (Supp. 1993); KAN. STAT. ANN. § 65-2869 (1985); ME. REV. STAT. ANN. tit. 32, § 3270 (West 1988); N.D. CENT. CODE § 43-17-01 (1978); OKLA. STAT. ANN. tit. 59, § 492 (West 1993); S.D. CODIFIED LAWS ANN. § 36-4-9 (1992); TENN. CODE ANN. § 63-6-204 (Supp. 1992); VT. STAT. ANN. tit. 26, § 1311 (1989); WYO. STAT. § 22-26-102 (1987). These states limit the scope of "the practice of medicine" to the treatment of disease, ailments,
practice of medicine, except in the case of "females engaged solely in the practice of midwifery."288 Michigan, Nevada, and Utah construe "the practice of medicine" broadly,289 increasing the vulnerability of midwifery to tighter medical control. The state of Washington was first to grant true professional autonomy to direct entry midwives.290 In an exciting move toward legislative recognition of an independent professional midwifery organization, the 1993 Colorado statute governing the practice of direct entry midwifery suggests that the state utilize a professional competency examination designed by the Midwives' Alliance of North America, Inc., an organization formed to support direct entry midwifery as well as nurse-midwifery.

C. Examples of Judicial Action

The U.S. Supreme Court has never decided a constitutional issue regarding midwifery. In 1977, the California Supreme Court held that a woman has no privacy right to choose "the manner and circumstances in which her baby is born."291 According to the California court, Roe v. Wade's trimester system precluded such a right.292 Since the state's interests are paramount over the woman's privacy rights in the final trimester of pregnancy, the court reasoned, it follows that her privacy rights cannot prevail during labor and birth.293 Thus, the state may require that birth attendants have valid licenses (and presumably may regulate midwifery in other ways as well), even when it has no laws prohibiting unattended childbirth outside the hospital.294 The court suggested that "further arguments as to the safety of home deliveries are more properly addressed to the Legislature than the courts."295

A recent federal case concerning the statutory treatment of midwifery similarly suggests that independent licensing standards may be best achieved through intensive state-by-state lobbying, and not by claiming in courts a "right" to practice midwifery. In Peckmann v. Thompson,296 two unlicensed
midwives challenged the constitutionality of the Illinois Medical Practice Act,297 under which they had been indicted for practicing midwifery without a license. Although the court found the statute unconstitutionally vague with respect to whether or not the legislature had intended to include midwifery in its definition of the practice of medicine, the court supported the constitutional validity of such a policy based on the police power of the state.298 The court deferred to the legislature:

Under the 1987 Medical Practice Act, Illinois eliminated the separate licensing procedure for midwives which it had previously employed. Although the wisdom of the change in treatment of midwives may be debated, there is nothing in the Constitution which prohibits Illinois from rationally exercising its police power towards midwives; the Constitution does not demand that midwifery be recognized or licensed in Illinois.299

Unless proponents can convince skeptical courts that midwifery is a

297. The Illinois Medical Practice Act of 1987 read:
If a person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefor, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnoses or attempts to diagnose, operates upon, professes to heal, prescribes for, or otherwise treats any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; . . . and does not possess a valid license issued pursuant to this Act, he shall be sentenced as provided


298. 745 F.Supp. at 1391. By stating its support for the constitutionality of medical licensing of midwives, the court may have given the green light to the Illinois legislature to expand its definition of medicine to include midwifery. The new Act reads as follows:
If any person does any of the following and does not possess a valid license issued under this Act, that person shall be sentenced as provided . . . : (i) holds himself or herself out to the public as being engaged in the diagnosis or treatment of physical or mental ailments or conditions including, but not limited to, deformities, diseases, disorders, or injuries of human beings; (ii) suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment or condition of any person with the intention of receiving, either directly or indirectly, any fee, gift, or compensation whatever; (iii) diagnoses or attempt to diagnose, operates upon, professes to heal, prescribes for or otherwise treats any ailment or condition, or supposed ailment or condition, or another; (iv) maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment or condition; or (v) attaches the title Doctor, Physician, Surgeon, M.D., D.O. or D.C., or any other word or abbreviation to his or her name indicating that he or she is engaged in the treatment of human ailments or conditions as a business.


In their complaint, the plaintiff midwives claimed that access to midwifery was a fundamental right, included in the right to privacy in reproductive decisions first identified by the Supreme Court in Griswold v. Connecticut, 381 U.S. 479 (1965). See supra notes 291-96 and accompanying text. Disposing of the case on a motion for summary judgment, the Peckmann court did not reach this issue.

For a discussion of a midwife’s due process right to practice her profession, see Reilly, supra note 291, at 1131-33. Reilly also discusses the "void for vagueness" claim that statutes that merely define the practice of medicine without specifying midwifery cannot be held to authorize the regulation of midwives.

Id. at 1133-35.

299. 745 F. Supp. at 1391.
fundamental constitutional right, prompting strict scrutiny of state regulations restricting its availability, activists should focus on convincing legislatures that independent licensing of midwifery is in the best interests of the state.

Proponents should present to legislators the evidence that changes in midwifery could save lives and money. Low birthweight is the major cause of infant mortality in both Europe and in the United States. Low birthweight infants "are forty times more likely to die within the first twenty-eight days of life than normal weight infants." Half of low birthweight babies have some degree of mental retardation; they also have a high incidence of epilepsy, cerebral palsy, and learning or behavioral problems.

The most logical and fiscally responsible way to deal with low birthweight is to prevent it in the first place. The alternative is to reduce the impact with expensive, "high tech" neonatal intensive care units (NICUs) and expanded medical care. The cost of saving these babies by the latter route is astronomical. In Florida, the medical costs for a premature, low birthweight baby has been estimated at between $16,136 and $174,278, and the approximate lifetime cost for custodial care of a low birthweight baby with complications is $500,000, not including costs for education and social and economic services.

Dr. Thomas Brewer, a leading expert on metabolic toxicity in pregnancy, says that the presence of more than six hundred neo-natal intensive care units in the United States today is "a crime against the health of our people. . . . A child in a neo-natal intensive care unit is an abused child. We don’t need 600 neo-natal intensive care units in a country that is as rich as ours. We have no standards." Five years earlier, activist Angela Davis had testified before the California Department of Consumer Affairs about the prevailing approach of the medical establishment to solving the crisis:

As growing numbers of medically indigent women are forced to go without prenatal care and proper nutrition, thus producing very low birth weight babies, every effort is made to keep those infants alive through the use of expensive, profit-making technology. . . . The


301. "Low birthweight" means that the infant was born 1) too soon; 2) too small (less than 5.5 pounds); or 3) both. CHILDREN’S DEFENSE FUND, MATERNAL AND INFANT HEALTH: KEY DATA, SPECIAL REPORT ONE 4 (Mar. 1990) at 10.

302. MENDELSOHN, supra note 171, at 37.

303. NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, supra note 291, at 14.

304. FLORIDA TASK FORCE ON GOV’T FINANCED HEALTH CARE, FINAL REPORT 29 (March 1991).

305. FLORIDA DEP’T OF HEALTH AND REHABILITATIVE SERV., supra note 291, at 6.

306. Dr. Thomas Brewer, Address at NAPSAC Summit (1986).
medical establishment’s . . . solution to an embarrassingly high rate of infant mortality in this country’s poor and Third World communities is increased reliance on the technological miracles that keep low birth weight babies alive, many of whom are born prematurely because their mothers could not obtain early equal respectful care . . . .

Professor Davis highlights the way in which NICUs are in fact an exorbitantly expensive and inadequate “band-aid” for a mostly preventable injury.

A large group of practicing midwives could increase participation in prenatal care and reduce the incidence of low birth weight and the need for neonatal intensive care units by providing more affordable, accessible services than the medically oriented status quo. The National Commission to Prevent Infant Mortality has suggested that even small improvements in preventive care would result in an immediate national savings of 70 to 95 million dollars.

Requiring midwives to first become nurses is unnecessary and counterproductive to the goal of increasing the number of midwives. Such a requirement would slow down the education process considerably, and might discourage those people who would like to become midwives but are not interested in nursing. The idea that midwifery is nursing is an unfortunate but correctable misconception. Midwife Caroline Flint writes,

“As a nurse you will learn to take care of bedsores and to prevent them, you will be able to scrub . . . amputations, . . . learn about congestive cardiac failure, how to make a bed, the care of . . . coronary thrombosis, subarachnoid hemorrhage, concussion, . . . kidney dialysis, giving medicines—all thoroughly useful knowledge which no sane person could do without before becoming a midwife?” Or is it?

A 1981 World Health Organization Organization Regional Office report noted that, because midwifery and nursing are separate disciplines, they should be studied, considered, and regulated separately.

The weight of the evidence and statistics suggests that states should create a system of regulation or certification to govern the practice of qualified.

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308. NATIONAL COMM’N. TO PREVENT INFANT MORTALITY, supra note 204, at 16.
309. Caroline Flint, Should Midwives Train as Florists?, NURSING TIMES, Feb. 12, 1986, at 21. Further, the experiences of other countries destroy the argument that direct-entry midwifery is novel and untested. “Far from being untested, direct entry midwifery education is far more tested than is nurse-midwifery. England, France, Belgium, The Netherlands, Germany, Austria, Denmark, Italy and Japan—all of which have lower infant mortality rates than the United States, have always had direct entry midwifery education.” Haire, supra note 126.
310. See OAKLEY & HOUD, supra note 153, at 184.
trained midwives. The ideal statute would allow a midwife to qualify as a professional if she had completed nursing and midwifery training, as required for nurse-midwives, or if she completed midwifery training and a comprehensive apprenticeship program. With statutory authority, midwifery could finally claim its rightful place as an independent profession.

VI. CONCLUSION

Because the safety of hospital and medically oriented birth is so questionable, the state’s interest in protecting mother and child is not served by a statute allowing total control by allopathic physicians over maternity care. The challenge is to create a system of regulation that ensures competence, involves consumers, and allows for independence. Using Washington’s midwifery laws as a model, states should design public policy to allow and encourage the development of an independent midwifery profession.

Five recent legislative events indicate that the international movement to recognize and promote midwifery is accelerating. Two populous states have passed bills allowing the training and licensing of direct-entry midwives—Florida in 1992 and California in 1993; Oregon law now authorizes a state agency to license direct-entry midwives. In 1993 Colorado enacted a law that requires registration of direct-entry midwives and recommends that registration be premised on passing an examination designed by a professional midwives’ association. Finally, the House of Commons Health Committee in the United Kingdom published new findings regarding maternity care.

A study conducted by the Florida Senate Committee for Health and Rehabilitative Services recommended prescribing core competencies for licensed midwives, encouraging hospitals and physicians to establish collaborative relationships with licensed midwives, developing collaborative relationships through county public health units to provide services to Medicaid clients, and encouraging physicians and certified nurse-midwives to provide


312. Reilley, *supra* note 291, at 1142. *Cf.* Evenson, *supra* note 311, at 329-30. Evenson writes: Present policies and attitudes appear to be at odds with developing better maternal/infant health care. The health care system should recognize qualified midwives, and thus promote greater safety in and support for home birth, instead of trying to prevent it through punitive measures.

The sensible solution is to license qualified, trained midwives—both nurse- and lay midwives—under a unified licensing provision which recognizes midwifery as an independent profession.

*Id.*


more home birth services. Committee Substitute for House Bill 553 passed and was signed into law by the Governor on April 8, 1992.

In 1992, in a move that the United States would be well-advised to emulate, the British House of Commons Health Committee issued recommendations that strongly favored the profession of midwifery:

On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouraging all women to give birth in hospitals cannot be justified on grounds of safety.

... .

We conclude that the experience of the hospital environment too often deters women from asserting control over their own bodies and too often leaves them feeling that, in retrospect, they have not had the best labour and delivery they could have hoped for.

Lawmakers can afford to ignore neither the risks involved in hospital birth nor the research and statistics validating the safety and importance of the midwifery profession. State power is supposed to provide for the general welfare of citizens and secure them against the consequences of ignorance, deception, and fraud. Broad medical practice acts that protect unsubstantiated medical assertions and make criminals of competent midwives provide no such security. If public policy is to improve the health of mothers and children, it must allow the profession of midwifery to develop fully, independently, and in its rightful place—the home.


317. HEALTH COMMITTEE, HOUSE OF COMMONS, 1 MATERNITY SERVICES ¶ 33, 100 (U.K. 1991-92 Sess.).