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Law

Legal Briefing: Home Birth and Midwifery

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ABSTRACT

This issue's "Legal Briefing" column covers recent legal developments involving home birth and midwifery in the United States. Specifically, we focus on new legislative, regulatory, and judicial acts that impact women's[1] access to direct entry (non-nurse) midwives. We categorize these legal developments into the following 12 categories.[2]

1. Background and History
2. Certified Nurse-Midwives
3. Direct Entry Midwives
4. Prohibition of Direct Entry Midwives
5. Enforcement of Prohibition
6. Challenges to Prohibition
7. Forbearance without License
8. Voluntary Licensure
9. Unclear and Uncertain Status
10. Growth of DEM Licensure
11. Licensure Restrictions
12. Medicaid Coverage

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1. BACKGROUND AND HISTORY

One hundred years ago, most births in the United States were home births.[3] Today, fewer than 1 percent of births take place in a home setting. Almost all U.S. births now occur inside a hospital setting.[4] Nevertheless, statistics from the U.S. Centers for Disease Control and Prevention (CDC) indicate that the low number of home births has significantly increased in recent years. Between 2004 and 2009, the percentage of home births jumped 29 percent, from 0.56 percent to 0.72 percent of the more than four million annual U.S. births.[5] Moreover, this is a national average. In eight states, the percentage of home births is 2 percent or higher.[6]

Despite this recent increase, the rate of home birth in the U.S. stands in sharp contrast to the rate of home birth in most other developed countries.[7] For example, while the Duchess of Cambridge recently famously decided to forgo a home birth,[8] 2.4 percent of women in the United Kingdom do have home birth.[9] In the Netherlands, the home birth rate is much higher, around 20 percent.[10] Notably, these and other European countries have a greater number of midwife-attended births, not only at home but also in hospitals and in freestanding birthing centers. This use of midwives across birth settings tends to make the systematic use of midwives out-of-hospital more acceptable. The normalization of midwifery care in one setting leads to the advancement of such care in other settings.[11] In contrast, the low 1 percent rate of home birth in the U.S. correlates to

the overall low 8 percent rate of all midwife-attended births.[12]

There are many reasons for the low rate of home birth in the U.S. Causal factors include: (1) historical and cultural factors such as disapproval of the medical community; (2) perceived safety concerns; and (3) women's lack of awareness of the ongoing practice of home birth and profession of midwifery, as fuelled by homogeneous depictions of hospital birth in the mainstream media.[13] But some of the most serious impediments to home birth are legal obstacles, such as criminal and regulatory restrictions on the ability of non-nurse-midwives to practice.[14] To be sure, restrictions on nurse-midwives also impact the availability of home birth. While additional nurse-midwives would like to be more involved, many are restricted by scope of practice and supervisory regulations.[15] In short, an examination of the legal status of home birth must naturally focus on the legal status of midwives.

Admittedly, some women give birth at home without the assistance of a medical or professional birth attendant. This practice is known as "unassisted childbirth or "freebirth."[16] Most U.S. home births, however, take place in the presence of a midwife.[17] There are two main types of midwives: (1) certified nurse-midwives and (2) direct entry midwives.

2. CERTIFIED NURSE-MIDWIVES

Certified nurse-midwives (CNMs) are registered nurses who have studied obstetrics and gynecology in a nurse-midwifery educational program that is accredited by the Accreditation Commission for Midwifery Education (ACME), the accrediting organization of the American College of Nurse-Midwives (ACNM).[18] After graduating with a master's or doctoral degree, these nurses are then certified as CNMs by the American Midwifery Certification Board (AMCB), the certifying organization of the ACNM.[19] The AMCB, in turn, is accredited by the National Commission for Certifying Agencies.

CNMs have the highest degree of academic medical training of all practicing midwives. CNMs are trained in both nursing and midwifery, and have a broad scope of practice. Consequently, they are able to provide a wide range of well-woman services beyond pregnancy and childbirth. Moreover, the legal status of CNMs is relatively settled. They are licensed in every state—sometimes as nurses and sometimes as CNMs. Their services are usually reimbursable by insurance. While CNMs are qualified to offer care both inside and outside hospitals, most of them focus on labor and delivery in a hospital setting.[20] CNMs attend fewer than one in five home births.[21] This ratio is most likely the result of the legal disincentives and outright prohibitions mentioned above, but may also be due to professional culture, lifestyle issues, and monetary concerns.

3. DIRECT ENTRY MIDWIVES

Most U.S. home births are attended by "direct entry midwives," individuals who train in the midwifery model of care[22] without becoming nurses. These non-nurse or "unmedicalized" midwives are trained in midwifery through a combination of self-study, schooling, and apprenticeship. There are three categories of direct entry midwives: (1) certified midwives, (2) certified professional midwives, and (3) "uncertified" midwives.[23] The legal status of these various types of midwives varies significantly from state to state, as discussed in Sections 4 to 11 below.

Certified Midwives

Certified midwives (CMs), like certified nurse-midwives, graduate with at least a master's degree from a midwifery education program accredited by the ACME.[24] Unlike CNMs, CMs do not need an RN (registered nursing) degree to become certified. On the other hand, it can be argued that the CM is closer to a non-nurse variation of the CNM credential, rather than a bona fide DEM type, due to the CM requirement of an advanced degree from an academic institution. CMs are quite rare.[25] They are licensed in only a handful of states.[26]

Certified Professional Midwives

Far more relevant to legal questions surrounding home birth are certified professional midwives (CPMs). The vast majority of home birth midwives are CPMs. These midwives are trained in midwifery and certified through the North American Registry of Midwives (NARM), the certifying body of the Midwives Alliance of North America (MANA).[27] NARM, in turn, is accredited by the National Commission for Certifying Agencies.[28] As discussed below in Section 10, over time, 26 states have licensed the CPM credential.[29]

There are two main routes to CPM certification.[30] First, a candidate can complete a formal midwifery education program that is accredited by the Midwifery Education Accreditation Council (MEAC). Second, a candidate can follow the "portfolio evaluation process" (PEP) pathway. The PEP neither requires nor grants a degree or diploma. Instead, the

candidate must complete an apprenticeship or internship program in which she attains minimum experience requirements (for example, a certain number of exams and births) and documents proficiency in midwifery skills.[31] This experiential model of education is not unique to CPM, but is emerging as a preferred method in many fields, such as engineering, business administration, and most recently, law.[32] Once certified, CPMs are required to recertify every few years. To this end, they must undertake continuing education and professional development.[33]

Uncertified Midwives

In contrast to CMs and CPMs, midwives who are not certified by either AMCB or NARM are, for the most part, also unlicensed.[34] Some uncertified midwives are religious birth attendants, who are arguably exempt from the legal framework governing nonreligious midwives.[35] Others are practicing cultural traditions or providing gratuitous services. These midwives are also often exempt from regulation.[36] However, many midwives believe the scope of states' religious exemptions to be broader than they actually are.

4. PROHIBITION OF DIRECT ENTRY MIDWIVES

Under the constitutional doctrine of privacy, a woman arguably cannot be restricted from giving birth in the location of her choosing. However, the law may restrict who may attend her. Across the U.S., there are four significant variations in the legal treatment of direct entry midwives (DEMs). First, some states license and regulate them. Second, some states permit DEMs to practice without licensure or regulation. Third, in some states, the legal status of DEMs is unclear and uncertain. Fourth, at the extreme of this spectrum, nine states criminally outlaw and prohibit the practice of direct entry midwifery.

The classic method by which state legislatures prohibit direct entry midwifery is by clarifying, through statute, that midwifery constitutes the practice of medicine (or nursing) and by then excluding DEM from the categories of person that can practice medicine (or nursing).[37]

Typically, states define the practice of medicine in an all-encompassing fashion to include all treating and diagnosing of any disease, injury, pain, or condition. This broad scope is limited only in its legal characterization of certain subsets of medicine as distinct professions, such as nursing. In other words, a practitioner can avoid the unauthorized practice of medicine only by practicing within the scope of another healthcare license.

Most CNMs therefore obtain licenses initially due to their nursing credentials.[38] However, in many states, no equivalent legal characterization is available to DEMs. Therefore, when a DEM practices midwifery in such a jurisdiction, she is committing the crime of practicing medicine without a license (often phrased as "the unauthorized practice of medicine").

Five states define direct entry midwifery as the unlicensed practice of medicine or the unlicensed practice of nurse midwifery: Illinois,[39] Iowa,[40] Kentucky,[41] Maryland,[42] and South Dakota.[43] Indiana also criminally prohibited direct entry midwifery and permitted only CNMs,[44] until a new statute, effective July 2013, instituted a new license for "certified direct entry midwives."[45]

North Carolina's prohibition is even more direct. The statute provides: "No person shall practice or offer to practice or hold oneself out to practice midwifery unless approved. . . ."[46] North Carolina only approves only CNMs to practice midwifery. Therefore, a DEM practicing in North Carolina would be "unapproved" and engaged in the unauthorized practice of midwifery.

Three other states have taken a very different and more circuitous approach to prohibition. For example, the relevant Alabama statute seems to permit practice by direct entry midwives with a license to practice midwifery. It states: "Nothing . . . shall be construed as to prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery as heretofore provided until such time as said permit may be revoked by the county board of health."[47] But in reality, the intention was simply to grandfather the existing midwives for some period of time and eventually replace them with nurse-midwives.[48]

In fact, the relevant Alabama health agencies have not issued any such licenses for decades.[49] Therefore, the official legal status of DEMs in Alabama is misleading and purely technical. No DEM may practice without a license. And no DEM has (or can get) a license.

Similarly, the relevant statutes in Georgia[50] and Rhode Island[51] potentially permit the licensing of DEMs. For example, the Rhode Island statute provides, "The state director of health is authorized and directed to make rules for the regulation of the practice of midwifery and for the licensing of midwives. . . ."[52] This statute, like many comparable ones, grants considerable discretion to the administrative agency charged with its implementation. In exercising its

discretion, the Rhode Island Department of Health promulgated rules for the practice of midwifery, authorizing only the practice of CNMs, not DEMs.[53] Georgia's administrative agency has exercised its discretion to limit the practice of midwifery to CNMs.

5. ENFORCEMENT OF PROHIBITION

The prohibition of direct entry midwifery is hardly a mere formality like archaic laws prohibiting women from wearing pants or laws prohibiting unmarried couples from living together. State attorneys actively prosecute midwives. The charges usually include: (1) the unauthorized practice of medicine, (2) child abuse, and (3) manslaughter. DEMs are most at danger of prosecution when they experience a bad outcome, especially the death of a baby. Occasionally, although rarely, prosecutors charge the mothers.[54] The restraining tactics employed against parents in such cases tend more often to be the involvement or threatened involvement of state child protective services agencies.

For more than a century, authorities have been charging DEMs with practicing medicine without a license.[55] One of the earliest and most famous cases was Massachusetts's prosecution of Hanna Porn in 1905.[56] A steady stream of prosecutions and convictions has continued ever since.[57] Over just the past few years, there have been dozens of prosecutions and convictions.[58] There have also been prosecutions of unlicensed midwives practicing in jurisdictions where a license is available.[59] When the baby or mother suffers a bad outcome, prosecutors often criminally charge the midwife with child abuse or manslaughter.[60]

Furthermore, in all states that do not affirmatively license DEMs, the mere threat of action by local law enforcement can exert a chilling effect on the practice of midwifery. As documented by midwives' personal accounts, the issuance of a cease and desist order is sufficient to cause midwives to go underground, stop practicing, or leave the state.[61] At best, the introduction of such a climate of fear may result in dangerous and excessively risk-averse practices by midwives, such as a reluctance to transfer a woman to a hospital, when transfer is indicated, or a refusal to accept clients with even the most minimal of risk factors.

In cases in which midwives are arrested, it is most likely, as with most criminal charges, that the defendant will accept a plea bargain rather than proceed to trial. Like people in other low-paid professions, midwives find the cost of hiring a defense attorney to be prohibitive. Court-appointed attorneys for the indigent are unlikely to understand the complexities of midwife prosecutions. All in all, the process of defending oneself against such charges is sufficiently punitive to destroy a woman's career in midwifery.[62]

Finally, while most of the legal barriers to home birth are legal barriers to DEM, pregnant women and mothers have themselves been sanctioned in at least five ways. First, they are charged with child endangerment or criminally negligent failure to seek medical attention.[63] Second, they have been taken into custody and forced to go to a hospital to give birth.[64] Third, they have been charged with child abuse.[65] Fourth, state child protection services workers have removed babies from their mothers' custody.[66] Fifth, even when authorities do not actually take any of these actions, the threat of such intervention is sufficient to cause parents to abandon plans for home birth.[67]

6. CHALLENGES TO PROHIBITION

For decades, DEMs have challenged criminal prohibitions on their practice. They have made five main constitutional arguments: (1) privacy, (2) due process, (3) equal protection, (4) First Amendment, and (5) vagueness. Almost all of these challenges have been unsuccessful.[68]

First, DEMs have argued that the criminal prohibition of DEM violates the woman's constitutional privacy right to choose a birth attendant. The courts have rejected this argument, holding that the right to privacy that protects a woman's right to have an abortion[69] has never been interpreted to also include the right to choose the manner and circumstances in which her baby is born.[70]

Second, DEMS have argued that treating nurse-midwives and non-nurse-midwives differently (permitting the former but not the latter) violates equal protection. Courts have rejected this argument too, holding that the distinction is reasonably related to the state's legitimate interest in protecting public health and safety.[71]

Third, DEMs have argued that the criminal prohibition of DEM deprives them of a substantive due process right to earn a living in their chosen profession. This argument fails for much the same reason as the equal protection argument. Since the right to earn a living is not a fundamental right, the courts have held that it is outweighed by state regulation reasonably related to the state's legitimate interest in protecting public health and safety.[72]

Fourth, DEMs have argued that the criminal prohibition of DEM violates their freedom of speech. In

contrast to the due process argument, speech is a fundamental right, triggering strict scrutiny analysis. Even these First Amendment challenges have failed. The courts have held that the states' licensing schemes are narrowly drawn to achieve the compelling state interest of protecting the health of mothers and children.[73]

Fifth, DEMs have argued that statutes prohibiting DEM are unconstitutionally vague. DEMs have contended that they could not determine what conduct was prohibited. These challenges have also usually failed.[74] The courts have held that most of these statutes explicitly and definitely state what conduct is punishable, thereby giving fair notice of what conduct is prohibited under the law.

In contrast to this track record of constitutional challenges by DEMs, pregnant women and new mothers have more successfully challenged criminal sanctions imposed on themselves for choosing home birth. For example, in *Massachusetts v. Pugh,* a woman failed to summon medical help during and after giving birth precipitously at home. The state obtained a conviction against her for criminal negligence. However, the Massachusetts Supreme Judicial Court reversed, holding that she had no duty to seek medical assistance.[75] The court explained: "Imposing a broad and ill-defined duty on all women to summon medical interventions during childbirth would threaten their liberty interest in refusing unwanted medical treatment."

Not only does the imposition of unwanted medical treatment threaten a woman's liberty interest, but her inability to procure healthcare constitutes a denial of human rights as evoked in three recent cases brought before the European Court of Human Rights. While these cases have no direct application to, or impact on, U.S. law; they are instructive and potentially persuasive.[76]

In *Ternovszky v. Hungary,* Anna Ternovszky alleged that she could not find adequate professional assistance for a home birth.[77] Due to the threat of prosecution, Hungarian midwives were dissuaded from assisting those wishing home birth. Ternovszky claimed that the uncertain legality of home birth midwifery interfered with the exercise of her rights under Article 8 of the European Court of Human Rights (ECHR) (respect for private and family life). The Court agreed. Hungary subsequently complied with the ECHR decision and authorized the licensing of home birth midwives. But the new Hungarian law excluded home birth midwifery from coverage under the national social insurance. And it also subjected home birth midwifery to extensive restrictions, such as prohibiting home births more than 20 minutes away from a hospital.[78] Nevertheless, it is exactly these remote locations that put women at higher risk for not receiving prenatal care, which midwives are well situated to provide.[79]

Anna Ternovszky's midwife, Agnes Gereb, was arrested in 2010. In 2012, she was sentenced to two years in prison for negligence related to two home birth fatalities from 2006 and 2007. She is currently under house arrest. A second case before the European Court of Human Rights alleges that Gereb did not receive a fair trial. Unlike other healthcare professionals who are held to the standards of their peers, Gereb was assessed against standards that were established by unqualified and biased experts.[80] This case is still pending.

In a third case before the European Court of Human Rights, several Lithuanian women complain that they cannot obtain adequate professional assistance in home birth because Lithuanian law prohibits and obstructs healthcare specialists who want to help pregnant women during home birth.[81] Lithuanian officials determined that the *Ternovszky* decision only emphasized the importance of legal certainty. They maintain, in opposition to the petitioners, that *Ternovszky* does not require the state to affirmatively establish a regulatory framework to allow home birth. This case is still pending.

7. FORBEARANCE WITHOUT LICENSE

In the United States, while DEM is prohibited in nine states (Alabama, Georgia, Iowa, Illinois, Kentucky, Maryland, North Carolina, Rhode Island, and South Dakota), DEMs in 11 other states (Connecticut, Kansas, Massachusetts, Maine, Michigan, Mississippi, Missouri, North Dakota, Nevada, Oklahoma, and Pennsylvania) have obtained (1) court decisions, (2) attorney general opinions, or (3) statutes holding that direct entry midwifery is not the practice of medicine or nursing. Therefore, DEM in these states falls outside the scope of the prohibition against the unlicensed practice of medicine. But while these states do not prohibit direct entry midwifery, they do not license or regulate it either.[82] Their posture has been one of forbearance or tolerance, in varying degrees. In these states midwives often consider their practice to be "alegal."

While, as discussed above, most constitutional challenges to the prohibition of DEM have failed, some statutory interpretation challenges have succeeded. In eight states, appellate courts have ruled that DEM is not the practice of medicine.[83] These states include: Connecticut,[84] Kansas,[85] Massachu-

setts,[86] Michigan,[87] Nevada,[88] North Dakota,[89] Oklahoma,[90] and Pennsylvania.[91]

In two other states, Maine[92] and Mississippi,[93] DEMs did not obtain a judicial decision. Instead, each state's attorney general issued an interpretive legal opinion holding that pregnancy and childbirth are not covered by the state's medical practice act.

In Missouri, DEMs have obtained a statute that provides direct entry midwifery is not the practice of medicine.[94] The Missouri law states that "any person who holds ministerial or tocological certification by an organization accredited . . . may provide [midwifery] services." The state medical association challenged the constitutionality of the statute, but the Missouri Supreme Court rejected the challenge and upheld the statute.[95]

Nevertheless, it is doubtful exactly what, if any, level of protection is actually afforded by these 11 states' court opinions, attorney general opinions, and statutes.[96] In theory, DEMs in these states should not be charged with the unauthorized practice of medicine/nursing. Regardless, local prosecutors may file charges, either in ignorance of state law or from a desire to challenge it. Such a challenge would be well founded. The U.S. Supreme Court was petitioned to take up an Illinois case that found practicing midwifery to be the practice of medicine. The Court's refusal to grant *certiorari*[97] indicates to prosecutors everywhere that the highest law of the land does not prevent them from issuing cease and desist orders to midwives or arresting them for the unauthorized practice of medicine or nursing.[98]

In addition, should an unlicensed midwife experience a bad outcome, prosecutors in the 11 states listed above might still charge her with reckless endangerment, negligent homicide, or some other criminal charge.[99] This stands in sharp contrast to the civil or disciplinary sanctions imposed on physicians or other licensed practitioners who experience bad outcomes. It is hard to imagine an arrest warrant being issued for a medical professional in the absence of egregious intentional conduct.

8. VOLUNTARY LICENSURE

Oregon and Utah have enacted unique "voluntary licensure" statutes: they permit practice by both licensed and unlicensed midwives. The Oregon statute has long provided that a license is "required only for purposes of reimbursement under medical assistance programs and is not required for the practice of direct entry midwifery."[100] In 2013, Oregon amended this statute[101] to allow a person to practice direct entry midwifery without a license, either if (1) the person is a licensed healthcare practitioner and midwifery services are within the scope of the person's license, or if (2) the person is acting as a "traditional midwife" and complies with a number of conditions like not using prescription drugs, not advertising, and making detailed informed consent disclosures on an approved form.[102]

Utah authorizes voluntary licensure through two statutes. One states: "Nothing in this chapter abridges, limits, or changes in any way the right of parents to deliver their baby where, when, how, and with whom they choose, regardless of licensure under this chapter."[103] The other statute provides that ". . . it is lawful to practice Direct-entry midwifery in the state without being licensed. . . . The practice of Direct-entry midwifery is not considered the practice of medicine, nursing, or nurse-midwifery."[104] So, in Utah, as in Oregon, a DEM can legally practice either with or without a license.

9. UNCLEAR AND UNCERTAIN LEGAL STATUS

Nine states prohibit DEM, 11 states tolerate it, and two states allow voluntary licensure. But in a fourth group of states, its legal status is unclear and uncertain. In these five states, no court opinion, attorney general opinion, or statute confirms that DEM constitutes the practice of medicine. But neither does any legal authority confirm that DEM does not constitute the practice of medicine. In the District of Columbia, Hawaii, Nebraska,[105] Ohio,[106] and West Virginia,[107] DEMs do not know, one way or the other, whether they can be, or will be, criminally charged with the unauthorized practice of medicine.[108]

The District of Columbia has long been categorized as a jurisdiction that prohibits DEM,[109] but a May 2013 decision from the D.C. Office of Administrative Hearings casts doubt on that assessment. The D.C. Department of Health charged Karen Carr with the unlicensed practice of nurse midwifery. In a lengthy and well-researched opinion, the administrative law judge (ALJ) dismissed those charges. The ALJ ruled that "lay midwifery [is] a practice separate from nurse midwifery, and one that the District of Columbia does not regulate."[110] Nevertheless, the decision is not binding precedent. Nor does it clarify whether DEM is separate from the practice of medicine. Therefore, the legal status of DEM in the District of Columbia remains uncertain.

10. GROWTH OF DEM LICENSURE

Even if the legality of DEM were certain, in the absence of licensure, the standards of practice would

remain unknowable. Licensure offers significant advantages beyond recognition and authorization. It benefits both midwives and families. Licensure benefits midwives by defining their scope of practice, clarifying what interventions they may provide without opening themselves to charges of the unauthorized practice of medicine, and affording an official imprimatur that confers a certain degree of legitimacy.[111]

At the same time, licensure benefits families by improving consumer protection and quality assurance. Licensure helps ensure that practitioners are minimally qualified. It assures that the practice is safer and more transparent, for example facilitating transfer to a hospital when indicated. Moreover, licensure provides a mechanism for regulating members of the profession by means of an internal oversight and disciplinary process.[112]

CNMs are licensed as nurses in every state.[113] In contrast, CMs are licensed in just three states: New Jersey,[114] New York,[115] and Rhode Island.[116] While not licensed, CMs are also permitted to practice in both Delaware[117] and Missouri.[118]

In CPM licensure there is substantial variation among the states. Since the development of the credential in 1994, the trend among the states has been to use the CPM as the basis for state licensure.[119] Some states developed their own standards and exams before the creation of the CPM credential.[120] Still other states do not require CPM certification, but allow CPMs to expedite licensure and bypass otherwise-required licensing requirements.[121]

Today, 26 states license and regulate DEMs.[122] The first eight states to do so, in the 1970s and 1980s, were Arizona,[123] Arkansas,[124] Delaware,[125] New Hampshire,[126] Louisiana,[127] New Mexico,[128] South Carolina,[129] and Texas.[130] During the 1990s, nine more states regulated DEMs: Alaska,[131] California,[132] Colorado,[133] Florida,[134] Minnesota,[135] Montana,[136] New York,[137] Oregon,[138] and Washington.[139] Lastly, during the 2000s, eight more states enacted legislation regulating DEMs: Idaho,[140] New Jersey,[141] Tennessee,[142] Utah,[143] Vermont,[144] Virginia,[145] Wisconsin,[146] and Wyoming.[147]

In 2013, Indiana enacted a statute authorizing the practice of DEMs, beginning 1 January 2014.[148] It urges the Indiana Medical Licensing Board, with input from a midwifery committee, to "Establish as a requirement for certification as a certified direct entry midwife the Certified Professional Midwife credentials developed by the North American Registry of Midwives or a successor organization."[149] The new law also establishes continuing education requirements and peer review procedures.

As this brief chronology suggests, there has been a distinct and steady trend toward expanded DEM licensure. And this trend continues. Organizations and associations supporting home birth and DEM have been politically active in many states. These include: the Internation Center for Traditional Childbearing, the North American Registry of Midwives,[150] the Big Push for Midwives,[151] Citizens for Midwifery,[152] the National Association of Certified Professional Midwives,[153] and the Midwives Alliance of North America.[154] Importantly, these advocacy efforts are also often supported by parents and doulas (professional birth assistants).

In 2013, new bills were introduced or reintroduced in a number of states, including: Alabama,[155] Illinois,[156] Massachusetts,[157] Maryland,[158] Michigan,[159] North Carolina,[160] and West Virginia.[161] Furthermore, some states have been moving to license DEMs through administrative, rather than legislative, action. For example, Pennsylvania currently does not license or regulate DEMs, but will soon promulgate rule-making authorizing a DEM license through its state board of medicine.[162]

11. LICENSURE RESTRICTIONS

Entry requirements are not the only obstacles to DEM practice. Even once licensed or permitted, midwives may not be able to legally practice because they cannot comply with restrictive license requirements.[163] State regulations typically limit the types of patients whom direct entry midwives can serve. For example, many states forbid DEMs to attend vaginal births after cesarean (VBAC), breech births, births of multiples, or other "high-risk" births. These restrictions are slowly being softened and removed. For example, 2011 legislation in Arizona required the state health department to adopt rules: (1) to reduce the regulatory burden on licensed midwives, (2) to expand the scope of practice (to include VBAC, for example), and (3) to link licensing standards to CPM certification.[164] While states remain divided over breech[165] and multiple births,[166] many now conditionally permit DEMs to attend VBAC.[167]

Nevertheless, all these patient-specific practice limitations are far less important than the most significant and material limitation on DEMs: a license requirement for physician supervision. Midwives must always make arrangements for medical care in the event of an unexpected change in risk status of the mother or child during the course of the pregnancy, labor, or birth that would exceed the midwife's scope of practice.[168] Consequently, some states that regulate midwives require that they have a

"collaborative agreement" or "affiliation" with a physician,[169] so that midwives may confer over complicated cases and potentially refer them to the physician.[170] Some states instead simply require consultation in specified circumstances.[171]

Other states, like California,[172] take this a step further and categorically require not just collaboration and consultation but physician supervision. Delaware requires only "collaboration," yet this is perceived to be just as onerous as a supervision requirement.[173] While supervision does not require the physical presence of the physician, the supervision requirement is still a material impediment for midwives, because they find it very difficult to find physicians who are willing to supervise them.[174] There are several possible reasons for such a refusal.

First, physicians may not be available in the rural area where the midwife works.[175] That is, they may not have "reasonable geographic and/or temporal proximity to the patient."[176] Second, supervising physicians are often afraid of increased liability. Third, it can be expensive. Physicians often pay substantially higher malpractice premiums when they supervise a midwife.[177] Fourth, some physicians object on philosophical or anti-competitive grounds.

Indeed, problems finding a physician supervisor are so great that one California judge refused to discipline a DEM who was practicing without supervision, because, despite the midwife's best efforts, no physician would enter such a relationship with her. While the California Medical Board is currently not enforcing this requirement, this state of affairs provides little comfort to California DEMs who are concerned about the legality of their practice.[178]

States have been considering amendments to eliminate or reduce the supervision or collaboration barrier. For example, in 2012, Louisiana enacted legislation limiting professional liability for physicians performing risk assessments for midwives.[179] While this directly benefits physicians, it also likely benefits midwives, because it makes physicians more likely to agree to perform required assessments. As of August 2013, California was still considering legislation to eliminate the supervision or collaboration barrier and give CPMs more autonomy.[180] Delaware tried to delete its collaboration requirement, but the final bill enacted did not contain the necessary language.[181]

12. MEDICAID AND OTHER INSURANCE COVERAGE

While the lack of DEM licensure and restrictions on DEM licensure are major barriers to home birth, they are not the only ones.[182] Many states do not require Medicaid or private insurance to cover midwifery care by direct entry midwives.[183] While the average hospital delivery costs around $30,000, charges for a DEM-attended home birth are far less: only a professional fee is charged, without accompanying facility fees.[184] But because most insurance companies do not offer coverage or reimbursement for this care, women who choose to have a delivery with a DEM often have to pay for their care out-of-pocket. Therefore, real access to midwifery services is restricted to women with financial means.[185]

This reimbursement situation is slowly changing. More states are requiring private insurers to include DEM services.[186] For example, in 2011, Vermont enacted legislation requiring health insurance policies to cover midwifery services and home birth.[187] Conversely, as more families lose employer-supplied health insurance and arrive at pregnancy with poorer coverage or none at all, an out-of-pocket home birth compares favorably to hospital birth paid entirely out-of-pocket or accompanied by high copays or deductibles. But the insurance coverage most important to pregnancy and birth is Medicaid.

Medicaid currently finances more than 40 percent of all U.S. births. States may offer Medicaid reimbursement to any healthcare professional licensed in the state. But even among the 26 states that license DEMs, Medicaid now pays for DEM services in fewer than 15 of those states.[188] The remaining states have elected not to include DEM coverage in their state Medicaid plans. However, pending federal legislation, the "Access to Certified Professional Midwives Act of 2013," would mandate the extension of Medicaid coverage to certified professional midwives.[189]

Federal amendments to public insurance programs may also expand access to home birth in another way. Medicare and Medicaid already require coverage for nurse-midwifery services.[190] In contrast to DEMs, CNMs are authorized to be paid directly for services that they are legally authorized to furnish under state law and that are of the type that would otherwise be covered if furnished by a physician or incident to a physician's services.[191] The Medicaid rate of reimbursement for CNMs had traditionally been at just 65 percent of the physician rate, but effective 1 January 2011, the Affordable Care Act (ACA) raised this to 100 percent.[192] While Medicare covers only a small percentage of births, it influences reimbursement levels of other payers. Increased reimbursement should lead to greater access and growth of the practice.[193] In contributing to more-independent CNM practice,[194] this increase

may also expand access to home birth attended by CNMs.

Two questions more open to debate are (1) whether Medicaid is currently restricted by law to reimburse only licensed practitioners, and (2) whether the Affordable Care Act's (ACA's) nondiscrimination provision will mandate inclusion in insurance plans for all licensed practitioners. In response to the first question, state Medicaid plans currently may include coverage by unlicensed providers. States that include such provisions do so in the context of home visiting services, rural health clinics, and substance abuse treatment; in some cases, supervision requirements apply. Theoretically, unlicensed midwives could likewise be included in state plans; however, as of 2007, the only states with Medicaid plans that reimbursed DEMs were Florida, New Hampshire, New Mexico, Oregon, South Carolina, Vermont, and Washington, all states that license CPMs.[195]

The second question, whether the ACA's provider nondiscrimination clause (§ 2706)[196] will mandate that insurance plans cover all licensed providers, seems to find agreement only in its lack of applicability to Medicaid (and other government-funded plans). It is intended to apply only to "group health plans and health insurance issuers offering group or individual coverage. . . ."[197] Opinions differ, however, as to the efficacy and enforceability of this provision, with nurse-practitioner[198] and chiropractor advocacy organizations[199] weighing in on the optimistic side, traditional medical organizations taking the opposite position,[200] and the federal government expecting insurers to implement § 2706 "using a good faith, reasonable interpretation of the law," without plans to issue any regulations on this section.[201] It seems, at the very least, premature to depend upon this section to "even up" inequalities in insurance coverage between CPMs and more mainstream maternity careproviders.

CONCLUSION

Restrictions on DEM practice impede significant quality improvement and cost reduction in prenatal care, labor, and delivery.[202] Moreover, the barriers to accessing midwife-attended home births disproportionately impact poor, minority, and rural women.[203]

Notably, the arguments for expanding access to DEM are very similar to those for removing the scope-of-practice barriers for nurse practitioners and for giving them a broader role in primary care. While physicians receive more training than nurses do in highly complex care, it is unclear that this extra training has a measurable impact on the quality and safety of routine primary care services. Just as liberalizing the nurse-practitioner scope of practice would expand access to rural and poor areas and bend the cost curve,[204] so too would removing barriers to direct entry midwifery.

Such barriers are not limited to the recipients of care, but apply also to potential careproviders, as the cost of advanced university degrees required of CNMs and CMs may be prohibitive to many prospective midwives. DEMs, on the other hand, can find training opportunities either within their communities or in a combination of local training arrangements and distance learning programs, thus allowing them to serve their communities of origin at a lower cost, while keeping local dollars in those communities. There they can hope to eventually set up shop as licensed midwives, in the process creating new jobs that also offer the best chance at providing culturally competent care for their particular communities.

In every way, then, the benefits furnished by this model of training and care bolster the legal and public health rationales for licensing DEMs. The U.S. Constitution allocates to each state the power to regulate behavior to preserve the health, safety, and welfare of its inhabitants. The states do not, however, grant licenses in order to promote monopoly within a field of healthcare or hinder competition between disparate healthcare providers in that field. Nor does an ambiguous level of legal protection benefit any of the parties involved: not midwives, who may practice safely and without state interference for decades, only to be arrested when the political wind shifts; not mothers, whose midwives may suddenly leave practice because of legal problems; and certainly not agents of law enforcement, whose duty to protect the citizens of their states requires a clear and certain knowledge of what behavior is permissible and what is not.

Furthermore, mothers have the human right to receive safe, accessible, affordable, respectful, and culturally competent care in pregnancy and childbirth. In addition, both constitutional and bioethical principles guarantee mothers a right to bodily integrity, a right to refuse care, and a right to care for their children as they see fit. Should a state erect obstacles to these rights, mothers will do what they always have done: what they must—whether this involves withholding information and trust from a state-imposed healthcare provider, or giving birth unattended for lack of an appropriate provider. Women cannot have full rights as mothers and citi-

zens if their right to give birth in the way they determine is best for them and their family is compromised by the state's refusal to license and regulate healthcare providers who can accommodate their needs.

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DISCLAIMER

Deborah Fisch advocates for legal recognition and oversight of Certified Professional Midwives in Michigan as a member of the executive committee of the Coalition to License CPMs.

NOTES

1. Most mothers and, indeed, midwives identify as women. We recognize that this is not always the case. While nevertheless following the custom of using female nouns and pronouns when discussing mothers and midwives, we acknowledge the complexities of gender identity in the context of our culture.

2. We focus on those laws impacting access to midwives and home birth. We do not address related issues concerning (a) access to freestanding birthing centers, (b) access to doulas, (c) the relationship between midwives and obstetricians, or the (d) informed consent obligations of obstetricians. Furthermore, given extreme variability in the legal treatment of midwifery in the United States, we do not have space to also examine at length the legal treatment of midwifery in other countries.

3. L.J. Reagan, *When Abortion was a Crime: Women, Medicine, and Law in the United States, 1867-1973* (Berkeley, Calif.: University of California Press, 1988).

4. A third location for births between the institution of the hospital and the autonomous home setting is the freestanding birth center.

5. M.F. MacDorman et al., "Home Births in the United States, 1990-2009," *NCHS Data Brief* 84 (January 2012). The authors noted that much of the increase was due to childbirth by older, married, White women. This suggests a grave lack of access to home birth maternity care by more marginalized populations. Groups like the International Center for Traditional Childbearing include in their mission the need to "develop and preserve the traditional role of the midwife in the Black community." *http://ictcmidwives.org/about-us/mission-statement/,* accessed 5 August 2013.

6. See MacDorman, note 5 above.

7. S. Goodman, "Piercing the Veil: The Marginalization of Midwifes in the United States," *Social Science and Medicine* 65, no. 3 (2007): 610-21.

8. B. Turner, "Duchess of Cambridge, Open Your Eyes to the Home Birth Revolution," *Telegraph*, 21 March 2013.

9. Office for National Statistics, "Characteristics of Birth 2, England and Wales, 2011 (Table 8)," *http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-279449,* accessed 5 August 2013.

10. R. de Vries et al., "What Does It Take To Have a Strong and Independent Profession of Midwifery? Lessons From the Netherlands," *Midwifery* (2013), *http://dx.doi.org/10.1016/j.midw.2013.07.007i,* accessed 5 August 2013.

11. W. Christiaens, M.J. Nieuwenhuijze, and R.G. de Vries, "Trends in the Medicalisation of Childbirth in Flanders and the Netherlands," *Midwifery* 29, no. 1 (2013): e1-8.

12. E.R. Declercq, "Trends in Midwife-Attended Births, 1989 to 2007," *Journal of Midwifery and Women's Health* 56, no. 2 (2011): 173-6.

13. Safety issues are hotly contested and fall outside the scope of this article. The history of midwifery and the reasons for its decline, since 1900, are also outside the scope of this article.

14. E.R. Declercq et al., "State Regulation, Payment Policies, and Nurse-Midwife Services," *Health Affairs* 17, no. 2 (1998): 190-200; M. Loecks, "Midwifery and the Law," in *Encyclopedia of Childbearing: Critical Perspectives,* ed. B. Rothman (Phoenix, Ariz.: Oryz Press, 1993), 255-8; V.V. Runes, "From Calling to Courtroom: A Survival Guide for Midwives," 2004, *http://www.fromcallingtocourtroom.net,* accessed 5 August 2013.

15. E.g., Cal. Bus. & Prof. Code § 2746.5; N.C. Gen. Stat. § 90-178.3(b). CNMs are specifically prohibited from attending home births in Alabama and Nebraska. Ala. Rev. Stat. § 34-19-8; Neb. Rev. Stat. § 38-613(3).

16. A. Hickman, "Born (Not So) Free: Legal Limits on the Practice of Unassisted Childbirth or Freebirthing in the United States," *Minnesota Law Review* 94, no. 5 (2010): 1651-81.

17. See MacDorman, note 5 above.

18. R.G. de Vries and R. Barroso, "Midwives among the Machines: Recreating Midwifery in the Late Twentieth Century," in *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period,* ed. H. Marland and A.M. Rafferty (New York: Routledge, 1997), 248-72. The main professional organization for CNMs is the American College of Nurse-Midwives (ACNM), *http://www.midwife.org,* accessed 5 August 2013.

19. *http://www.amcbmidwife.org/home,* accessed 5 August 2013.

20. American College of Nurse-Midwives, "Issue Brief: Where Midwives Work," May 2012, *http://midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000277/Where%20Midwives%20Work%20June2012.pdf,* accessed 5 August 2013; Maryland Department of Health and Mental Hygiene, Midwives Working Group, "Meeting Minutes," 23 August 2012, *http://dhmh.maryland.gov/midwives/SitePages/Meetings.aspx,* accessed 5 August 2013.

21. See MacDorman, note 5 above.

22. See *http://cfmidwifery.org/mmoc/brochure_text.aspx,* accessed 5 August 2013.

23. DEMs are often referred to as "lay" midwives, a term implying that DEMs are untrained. In fact, these midwives usually have considerable training, merely less formal and academic than that of their hospital-based counterparts. Their training is also specialized to the conditions of out-of-hospital birth. J.P. Rooks, *Midwifery and Childbirth in America* (Philadelphia, Pa.: Temple University Press, 1999). We depart from customary usage, here, in order to employ a more descriptive and neutral term.

24. *http://www.amcbmidwife.org/amcb-certification/why-amcb-certification-,* accessed 5 August 2013.

25. The ACMB annual report for 2012, reports that the annual number of new CMs between 2000-2012 has ranged from two to 15, with an average of five. *http://www.amcb midwife.org/docs/annual-reports/amcb-annual-report-2012.pdf?sfvrsn=2,* accessed 5 August 2013.

26. See Section 10 above.

27. *http://www.mana.org/,* accessed 5 August 2013.

28. *http://www.credentialingexcellence.org/p/cm/ld/fid=121,* accessed 5 August 2013.

29. Before the advent of the CPM credential in 1994, individual states that licensed midwives each established their own requirements and standards. Since the availability of the CPM credential, the trend has been to use the CPM as the sole basis, or at least as an essential basis, for state licensure. See Section 10 above.

30. NARM also provides expedited paths for CNMs/CMs and other experienced midwives to obtain CPM certification.

31. *http://narm.org/entry-level-applicants/,* accessed 5 August 2013.

32. *http://www.abajournal.com/news/article/law_school_curricula_are_changing_survey_shows/,* accessed 5 August 2013.

33. *http://www.nacpm.org/,* accessed 5 August 2013.

34. R.G. de Vries, *Regulating Birth: Midwives, Medicine and the Law* (Philadelphia, Pa.: Temple University Press 1985); J.D. Rooks, *Midwifery and Childbirth in America* (Philadelphia, Pa.: Temple University Press 1997): 225-30.

35. *Northup v. Superior Court,* 237 Cal. Rptr. 255, 192 Cal. App. 3d 276 (1987).

36. E.g., Alaska Stat. § 08.65.170; Ark. Code Ann. § 17-85-105; Wash. Rev. Code. §§ 18.50.010 & 18.50.030.

37. Indiana recently established licensure for DEMs. But a pre-licensure case defined DEM as the unlicensed practice of medicine. *Smith v. State,* 459 N.E.2d 401 (Ind. App. 1984). Virginia repealed its prohibition of DEM in 2003. But an earlier statute specifically prohibited DEM. Va. Code Ann. § 32.1-147 ("All subsequent licensure for midwifery shall be limited to registered nurses who are trained as nurse-midwives. . . .").

38. A. Reed and J.E. Roberts, "State Regulation of Midwives: Issues and Options," *Journal of Midwifery and Women's Health* 45, no. 2 (2000): 130-49.

39. 225 Ill. Comp. Stat. Ann. §§ 60/3 & 60/3.5; *People v. Arendt,* 60 Ill. App. 89 (1895); *People v. Jihan,* 537 N.E.2d 751 (Ill. 1989); *Peckman v. Thompson,* 745 F. Supp. 1388 (N.D. Ill. 1990); *People v. Cryns,* 786 N.E.2d 139 (Ill. 2003); *Morris v. Department of Professional Regulation,* 824 N.E.2d 1151 (Ill. App. 2005). But see also *People v. Jihan,* 537 N.E.2d 751 (Ill. 1989); *Peckmann v. Thompson,* 745 F. Supp. 1388 (N.D. Ill. 1990).

40. Iowa Code Ann. §§ 147.2 & 148.1; 78 Iowa Attorney General Opinion 371 (1978).

41. Ky. Rev. Stat. Ann. §§ 311.560 & 314.043.

42. Md. Health Occupations Code §§ 8-503, 8-701 & 14-301; Hunter v. State, 676 A.2d 968 (Md. App. 1966).

43. S.D. Codified Laws § 36-4-8; South Dakota Board of Nursing v. Jones, 566 N.W.2d 142 (S.D. 1997).

44. Ind. Code §§ 25-22.5-8-2(b) & 25-23-1-13.1(a); *Smith v. State,* 459 S.E.2d 401 (Ind. App. 1984).

45. Ind. H.B. 1135 (2013) (Lehe), enacted as Ind. Pub. L. No. 232, codified at Ind. Code § 25-23.4-1.

46. N.C. Gen. Stat. § 90-178.3(a).

47. Ala. Code § 34-19-3.

48. Alabama's long history of safe and effective practice by African-American "granny" (or "grand") midwives is believed to have been cut short by the enactment of midwife licensure. In the early 20th century, the legislature required "lay midwives" to register with the state board of health in order to receive permits. Increasing amounts of supervision by medical and state public health personnel were instituted, culminating in the termination of the legal practice of "lay midwifery" in 1976, when the legislature restricted the practice of midwifery to nurse-midwives. S. Tovino, "American Midwifery Litigation and State Legislative Preference for Physician-Controlled Childbirth," *Cardozo Women's Law Journal* 11, no. 1 (2004): 61-106.

49. *State v. Kimpel,* 665 So. 2d 990 (Ala. Crim. App. 1995).

50. Ga. Code. Ann. § 31-26-2.

51. R.I. Gen. Laws § 23-13-9.

52. Ibid.

53. R23-13-MID R.I. Code R. § 1.6. (2012). Before it enacted a statute permitting the practice of DEM, this also used to be the approach that Missouri took to prohibiting DEM. Illinois General Assembly Legislative Research Unit, "Midwifery Licensing in Other States," 14 February 2008, *http://www.ilga.gov/commission/lru/37.Midwife Licensing.pdf,* accessed 5 August 2013.

54. L.M. Paltrow and J. Flavin, "Arrests of and Forced Intervention on Pregnant Women in the United States, 1973-2005: Implications for Women's Legal Status and Public Health," *Journal of Health Politics, Policy, and Law* 38, no. 2 (2013): 299-343.

55. *People v. Arendt,* 60 Ill. App. 89 (1895); People v. Cosper, 245 P. 466 (Cal. App. 1926); *Commonwealth v. Porn,* 82 N.E. 31 (Mass. 1907).

56. *Commonwealth v. Porn*, 82 N.E. 31 (Mass. 1907); E.R. Declercq, "The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts," *American Journal of Public Health* 84, no. 6 (1994): 1022-8.

57. Dozens of cases are collected by the advocacy and support group Sisters in Chains. *http://sistersinchains.org,* accessed 5 August 2013; S. Corcoran, "To Become a Midwife: Reducing Legal Barriers to Entry into the Midwifery Profession," *Washington University Law Quarterly* 80, no. 2 (2002): 649-74. *Sherman v. Cryns,* no. 2-01-0952, 2002

Ill. App. LEXIS 61 (28 January 2002); *People v. Odam,* 69 Cal. App. 4th 184 (1999); *Hunter v. Maryland,* 676 A.2d 968 (Md. Ct. Spec. App. 1996); *Colorado v. Rosburg,* 805 P.2d 432 (Colo. 1991); *Mo. State Bd. of Registration for the Healing Arts v. Southworth,* 704 S.W.2d 219 (Mo. 1986); *Leigh v. Board of Registration in Nursing,* 481 N.E.2d 1347 (Mass. App. 1985); *Smith v. State,* 459 N.E.2d 401 (Ind. App. 1984); *Bowland v. Santa Cruz,* 556 P.2d 1081 (Cal. 1976).

58. E.g., D. Denny, "Midwives: New Law Is Step in the Right Direction," *Herald Times,* 16 June 2013 (Jennifer Williams); "Midwife Arrest Protesters in LaGrange," *Fort Wayne Journal Gazette*, 11 April 2012; R. Rowe, "Two Midwives Arrested on Felony Charges," *Goshen News*, 4 April 2012, (Irene Keeslar); M. Gellatly, "S.C. Midwife Indicted for Indiana Deliveries," *Aiken Standard*, 4 April 2013.

59. M. Hennessy-Fiske, "Student Midwife Found Guilty," *Los Angeles Times*, 9 August 2011 (Katherine McCall).

60. M. McFall, Unlicensed Utah Midwife Charged in Newborn's Death," *Saint Louis Tribune,* 19 June 2013; C. Blake, "Death Sparks Midwife Rule Debate," *Asheville Citizen Times,* 6 April 2013; D. Malloy, "Judge Reluctantly Acquits Midwife," *Pittsburgh Post-Gazette,* 24 April 2009. Of course, sometimes the midwife really is culpable, for example, in delaying medically indicated transfer. Professional discipline sanctions and civil liability are imposed in such situations. E.g., A. Dutton, "Idaho Board Bans Meridian Midwives," *Idaho Statesman,* 8 August 2012; J. White and S. Kinzie, "Midwife Convicted in Death of Infant," *Washington Post,* 6 May 2011.

61. *http://www.gentlebirth.org/archives/illinois.html,* accessed 5 August 2013; *http://www.fromcalling tocourtroom.net/chap6.htm,* accessed 5 August 2013; *http://www.midwiferytoday.com/articles/answering questionhomebirth.asp,* accessed 5 August 2013; *http://wheresmymidwife.org/2013/04/25/history-lesson/,* accessed 5 August 2013.

62. Sisters in Chains, *http://www.sistersinchains.org/the-cost-of-persecution.html,* accessed 5 August 2013.

63. See Paltrow and Flavin, note 54 above, citing S*tate v. Greenup,* no. 2003-300B (La. Dist. Ct. St. John the Baptist Parish 16 August 2004); *People v. Portellos,* 827 N.W.2d 725 (Mich. 2012).

64. P*emberton v. Tallahassee Memorial Regional Medical Center,* 66 F. Supp. 2d 1247 (N.D. Fla. 1999); H.R. Bower, "How Far Can a State Go to Protect a Fetus? The Rebecca Comeau Story," *Golden Gate University Law Review* 31, no. 2 (2001): 123-54.

65. *Commonwealth v. Pugh,* 2009 WL 890988 (Mass. Super. 2009).

66. A. Bayer, "Baby Born via Home Birth Taken from Parents," *Examiner*, 2 September 2010.

67. "When the ultrasound showed twins, I was referred to a high-risk practice. The only discussion of 'options' was the date when my cesarean would be scheduled. When I tried to ask about how the risks of twins birth applied in my personal case, I received frowns but no answers. I explained that I wanted to attempt a physiological birth unless there was evidence that intervention was needed in my case. I was told that this kind of birth would not be allowed at any hospital in the area. When I said that I was looking for a midwife who could support a physiological twins birth, the OB said that she would have no choice but to call Child Protective Services." H. Hayes-Klein, "Informed Consent in Childbirth: Making Rights into Reality," 9 July 2013, *http://www.improvingbirth.org/2013/07/informed-consent-in-childbirth/,* accessed 5 August 2013.

68. As discussed above in Section 7, some constitutional challenges on the basis of statutory vagueness have been more successful. E.g., *People v. Jihan,* 537 N.E.2d 751 (Ill. 1989); *Pavek v. State,* 737 S.W.2d 136 (Tex. Crim. 1987).

69. *Roe v. Wade,* 410 U.S. 113 (1973); *Planned Parenthood v. Casey,* 505 U.S. 833 (1992).

70. *Connecticut v. Menillo,* 423 U.S. 9 (1975); *Bowland v. Santa Cruz,* 556 P.2d 1081 (Cal. 1976); *Colorado v. Rosburg,* 805 P.2d 432 (Colo. 1991); *State v. Kimpel,* 665 So. 2d 990 (Ala. App. 1995); *Leigh v. Board of Registration,* 481 N.E.2d 1347 (Mass. 1985); *Lange-Kessler v. New York Department of Education,* 109 F.3d 137 (2d Cir. 1999); *Sammon v. New Jersey Board of Medical Examiners,* 66 F.3d 639 (3d Cir. 1995); *Hunter v. State,* 676 A.2d 968 (Md. Ct. Spec. App. 1996).

71. *Colorado v. Rosburg,* 805 P.2d 432 (Colo. 1991); *Leigh v. Board of Registration,* 481 N.E.2d 1347 (Mass. 1985); *State v. Kimpel,* 665 So. 2d 990 (Ala. App. 1995).

72. *Lange-Kessler v. New York Department of Education,* 109 F.3d 137 (2d Cir. 1999); *Leigh v. Board of Registration,* 481 N.E.2d 1347 (Mass. 1985); *Firman v. Board of Medicine,* 697 A.2d 291 (Pa. Commonwealth 1997); *Sammon v. New Jersey Board of Medical Examiners,* 66 F.3d 639 (3d Cir. 1995); *Hunter v. State,* 676 A.2d 968 (Md. Ct. Spec. App. 1996); *Sherman v. Cryns,* 786 N.E.2d 139 (Ill. 2003).

73. *Dickerson v. Stuart,* 877 F. Supp. 1556 (M.D. Fla. 1995); *Lange-Kessler v. New York Department of Education,* 109 F.3d 137 (2d Cir. 1999).

74. *Bowland v. Santa Cruz,* 556 P.2d 1081 (Cal. 1976); *Sherman v. Cryns,* 786 N.E.2d 139 (Ill. 2003); *Dickerson v. Stuart,* 877 F. Supp. 1556 (M.D. Fla. 1995); *Colorado v. Rosburg,* 805 P.2d 432 (Colo. 1991); *State v. Kimpel,* 665 So. 2d 990 (Ala. App. 1995); *Missouri Board of Registration for the Healing Arts v. Southworth,* 704 S.W.2d 219 (Mo. 1986).

75. *Commonwealth v. Pugh,* No. SJC-10895 (Mass. 15 June 2012) *Commonwealth v. Pugh,* No. WOCR 2007-1323 (Worcester Sup. Ct. January 26, 2009).

76. *Graham v. Florida,* 130 S. Ct. 2011 (2010).

77. *Ternovszky v. Hungary,* No. 67545/09 (ECHR 14 December 2010).

78. MTI, "Homebirth midwife sentenced to imprisonment," *caboodle.hu: The Hungarian Portal,* 3 March 2011, *http://www.caboodle.hu/nc/news/news_archive/single_page/article/11/homebirth_mi-1/,* accessed 9 September 2013. See also International Conference of Jurists, Midwives, and Obstetricians, Conference Papers: Human Rights in Childbirth, 2012, *http://humanrightsinchild*

birth.com, accessed 5 August 2013.

79. Although this article discusses mostly care during labor and birth, a distinctive feature of midwifery is its prenatal care, characterized by the provision of extensive support and the close relationship developed with clients and their families.

80. *Gereb v. Hungary,* no. 64516/10 (ECHR 29 October 2010).

81. *Kosaite-Cypiene v. Lithuania,* no. 69489/12 (ECHR 19 October 2012).

82. For this position, many cite L.D. Hermer, "Midwifery: Strategies on the Road to Universal Legislation," *Health Matrix* 13, no. 2 (2003): 325-70.

83. *Leggett v. Tennessee Board of Nursing,* 612 S.W.2d 476 (Tenn. App. 1980). Other courts have made similar holdings. E.g., *In re Osborn,* no. 1999-040052, 1M-98-83794 (Cal. AOH 1999); *Peckman v. Thompson,* 745 F. Supp. 1358 (C.D. Ill. 1990); Banti v. State, 289 S.W.2d 244 (Tex. Crim. 1956).

84. *Albini v. Connecticut Medical Examining Board,* 51 Conn. L. Rptr. 798, 2013 WL 3673836 (Conn. Super. Ct. 2013).

85. *State Board of Nursing v. Ruebke,* 913 P.2d 142 (Kan. 1996).

86. *Leigh v. Board of Registration in Nursing,* 481 N.E.2d 1347 (Mass. App. 1985).

87. *People v. Hildy,* 286 N.W.2d 819 (Mich. 1939).

88. C. Wolfson, "Midwives and Home Birth: Social, Medical, and Legal Perspectives," *Hastings Law Journal* 37 (1985-1986): 909-76, citing *Pierce v. Douglas County District Attorney,* no. 12273 (9th Dist. Ct. Nev. 19 February 1982).

89. See Hermer, note 82 above.

90. Ibid.

91. *Goslin v. State Board of Medicine,* 949 A.2d 372 (Pa. 2008).

92. The following sources have been used to support the characterization of Maine as a state that tolerates DEM: Maine Attorney General Opinion (27 January 1978); Me. Rev. Stat. Ann. tit 32 § 13811; Me. Code Regs. §§ 02-392 ch.1(8A) & ch.33; *http://midwivesofmaine.org/faq.php,* accessed 5 August 2013.

93. Mississippi Attorney General Opinion 91-0445 (28 June 1991), 1991 *Westlaw* 577650; Miss. Stat. Ann. § 73-25-33.

94. Mo. Stat. Ann. § 376.1753. An earlier decision, predating the 2007 statute, upheld an injunction forbidding a DEM from practicing. *Missouri Board of Registration for the Healing Arts v. Southworth,* 704 S.W.2d 219 (Mo. 1986). Wyoming now licenses DEMs. But before 2003, Wyoming had a statute that excluded midwives from the practice of medicine. Wyo. Stat. Ann. § 33-26-103.

95. *Missouri State Medical Association v. State,* 256 S.W.3d 85 (Mo. 2008).

96. See three chapters in *From Calling to Courtroom,* note 14 above: C. Craven, "Why You Aren't Safe," V.V. Runes, "The Illusion of Safe Practice," and I. Darragh, "The Myth of the 'Alegal' Midwife."

97. *People v. Cryns,* 786 N.E.2d 139 (Ill. 2003), cert. denied (2003).

98. We are indebted to Katherine Prown of the Big Push for Midwives for her insight on this question. Email from Katherine Prown (30 March 2013) (on file with authors).

99. E.g., "Attorney: Law Used to Charge Midwife too Vague" *Springfield News Leader,* 7 July 2011; O. Uyttebrook, "Midwife Faces Child Abuse Charges," *Albuquerque Journal,* 11 September 2012; L. Tobias, "A Tragic Impetus to Certify Midwives," *Oregonian,* 6 July 2013.

100. Ore. Rev. Stat. § 687.415.

101. Ore. H.B. 2997 (2013) (Keny-Guyer), enacted as Ore. Laws ch. 657.

102. Ore. Rev. Stat. § 687.415.

103. Utah Code Ann. § 58-77-304.

104. Utah Code Ann. § 58-77-501.

105. In Hawaii, CNMs are the only midwives specified in statute and rules. Haw. Rev. Stat. § 457-1; Haw. Admin. Reg. § 16-89-81(c)(3). In Alabama and Nebraska, even CNMs are prohibited from performing home births. "A certified nurse midwife may perform authorized medical functions only in the following settings . . . a certified nurse midwife shall not attend a home delivery." Neb. Rev. Stat. § 38-613(3). Bills in recent legislative sessions have sought to amend this. Neb. L.B. 428 (2013); Neb. L.B. 712 (2012). "All deliveries must be planned to take place in the hospital." A similar restriction applies in Alabama. Ala. Rev. Stat. § 34-19-8.

106. J.M. Storck, "A State of Uncertainty: Ohio's Deficient Scheme of Midwifery Regulation in Historical and National Context," *Quinnipiac Health Law Journal* 89, no. 1 (2004-2005): 89-107; Ohio Families for Safe Birth, *http://safebirthohio.org,* accessed 5 August 2013.

107. *http://midwivesallianceofwv.com,* accessed 5 August 2013.

108. See *From Calling to Courtroom,* note 14 above.

109. D.C. Code §§ 7-751.01(6) & 3-1201.02(7).

110. *Carr v. Department of Health,* no. 2011-DOH-0002 (D.C. Admin. 22 May 2013) (Mangan, J.).

111. Even if a midwife is licensed, she might exceed the licensed scope of practice, and thus be engaged in the unauthorized practice of medicine. E.g., *Smith v. State,* 459 N.E.2d 401 (Ind. App. 1984); *Morris v. Department of Professional Regulation,* 824 N.E.2d 1151 (Ill. App. 2005); *People v. McCall,* no. B236269, 2013 WL 1140380 (Cal. App. 2013).

112. *Dent v. West Virginia,* 129 US 114 (1889) and C. Rausch, "The Midwife and the Forceps: The Wild Terrain of Midwifery Law in the United States and Where North Dakota is Heading in the Birthing Debate," *North Dakota Law Review* 84 (2008) 219-255.

113. *http://amcbmidwife.org/amcb-certification/why-amcb-certification-,* accessed 5 August 2013.

114. N.J. Admin. Code § 13:35-2A.2-4.

115. N.Y. Educ. L. § 6955; N.Y. Commissioner Reg. § 79-5; N.Y., Office of the Professions, "Midwifery: Questions and Answers," *http://op.nysed.gov/prof/midwife/midwifeqa/htm,* accessed 5 August 2013.

116. R.I. Gen. Laws § 23-13-9; R23-13-MID R.I. Code R. § 1.6. (2012).

117. Del. Code Regs. 16-4000-4106 §3.0 (2002).

118. Mo. Stat. Ann. § 376.1753.

119. Among others, the following states use CPM certification as a basis for licensure: Delaware, Idaho, Louisiana, Minnesota, New Jersey, Tennessee, Utah, Vermont, Virginia, and Wisconsin. Big Push for Midwives, "State Regulation PushChart" (May 2013), *http://pushformidwives.org/wp-content/uploads/2013/05/Push-for-Midwives-State-Regulation-PushChart_MAY-2013.pdf,* accessed 5 August 2013.

120. Among others, the following states use their own standards and tests in addition to, or instead of, CPM certification: Alaska, Arkansas, California, Colorado, Florida, Montana, New Hampshire, South Carolina, Texas, and Washington.

121. The following states allow CPMs to bypass certain licensure requirements: Colorado, New Mexico, and Texas.

122. See Big Push for Midwives, note 119 above. The Big Push lists 26 states as regulating CPMs, with an additional two (Maine and Missouri) legalizing CPMs. We categorize Maine and Missouri in Section 7, above.

123. Ariz. Rev. Stat. Ann. §§ 36-751 to -760; Ariz. Admin. Rules R9-16-101 to -112.

124. Ark. Code Ann. §§ 17-85-101 to -108; Ark. Admin. Code § 007.13.3-.300.

125. Del. Code tit. 16 § 122(3)(h); 16 Del. Code Reg. § 4106.

126. N.H. Rev. Stat. Ann. §§ 326-D:1 to D:14.

127. La. Rev. Stat. Ann. §§ 37:3240 to 37:3259.

128. N.M. Stat. Ann. § 9-7-6(F); N.M. Admin. Code tit. 16 §§ 11.3.1 to 11.3.14.

129. S.C. Code Ann. § 44-89-30; S.C. Code Reg. § 61-24.

130. Tex. Occ. Code §§ 203.001 to 205.505; Tex. Admin. Code §§ 831.11 to .13.

131. Alaska Stat. §§ 08.65.010 to .190; 12 Alaska Admin. Code § 14.110-.300.

132. Cal. Bus. & Prof. Code §§ 2521; Cal. Code Reg. tit. 16 § 1379.

133. Colo. Rev. Stat. §§ 12-37-101 to -110; Colo. Code Reg. § 739-1.

134. Fla. Stat. Ann. §§ 467.001 to .207; Fla. Admin. Code §§ 64B24-7.001 to .018.

135. Minn. Stat. Ann. §§ 147D.01 to .27.

136. Mont. Code Ann. §§ 37-27-101 to -325; Mont. Admin. R. §§ 24.111.601 to .613.

137. N.Y. Educ. L. §§ 6950 to 6958.

138. Ore. Rev. Stat. Ann. §§ 687.405 to .991; Ore. Admin Code §§ 332-015-0000 to 0080.

139. Wash. Rev. Code Ann. §§ 18.50.005 to .900; Wash. Admin. Code § 246-834.

140. Idaho Code Ann. §§ 54-5501 to 5513; Idaho Admin. Code r. 24.26.01.

141. N.J. Stat. Ann. §§ 45:10 to 10-22; N.J. Admin. Code §§ 13:35-2A.1 to .17.

142. Tenn. Code Ann. §§ 63-29-101 to -116; Tenn. Comp. R. & Reg. §§ 1050-5-.01 to.19.

143. Utah Code Ann. §§ 58-77-101 to -603; Utah Admin. Code R. §§ 156-77-101 to -604.

144. Vt. Stat. Ann. tit. 26 §§ 4181 to 4191; Vt. Code Reg. § 04-030-360.

145. Va. Code § 54.1-2957.7 to n-.13; 18 Va. Admin. Code §§ 85-130-10 to -170.

146. Wis. Stat. §§ 440.9805 to .988; Wisc. Admin. Code § 182.01 to -.30.

147. Wyo. Stat. §§ 33-46-101 to -108; Board of Midwifery Rules and Regulations, *http://plboards.state.wy.us/midwifery/RulesRegs.asps,* 006-195-001 Wyo. Code R. (2013), accessed 5 August 2013.

148. Ind. H.B. 1135 (2013) (Lehe), enacted as Ind. Pub. L. No. 232.

149. Ind. Code § 25-23.

150. *http://narm.org/advocacy/,* accessed 5 August 2013.

151. *http://pushformidwives.org/,* accessed 5 August 2013.

152. *http://cfmidwifery.org/index,* accessed 5 August 2013.

153. *http://www.nacpm.org/,* accessed 5 August 2013.

154. *http://www.mana.org/,* accessed 5 August 2013.

155. Ala. H.B. 178 (2013); Ala. S.B. 246 (2013).

156. Ill. H.B. 2685 (2013); Ill. H.B. 3636 (2013).

157. Mass. S.B. 1081 (2013); Mass. H.B. 2008 (2013).

158. Md. H.B. 1202 (2013).

159. Mich. H.B. 4749 (2013); Mich. S.B. 292 (2013).

160. Home Birth Freedom Act, N.C. S.B. 106 (2013); Decriminalize Direct Entry Midwifery, N.C. S.B. 107 (2013); N.C. H.B. 154; N.C. H.B. 155 (2013).

161. W.V. H.B. 2755 (2013).

162. 43 Pa. Bulletin 3813, 6 July 2013; B. Toland, "Proposal Makes Big Push for PA Midwives," *Pittsburgh Post-Gazette,* 26 July 2013.

163. See Tovino, note 48 above; J. Block, *Pushed: The Painful Truth about Childbirth and Modern Maternity Care* (Cambridge, Mass.: DeCapo Press, 2007), 181.

164. Ariz. H.B. 2247 (2012), enacted as Laws 2012 ch. 93. The regulations were implemented by 19 Ariz. Admin. Reg. 1805 (19 July 2013).

165. Some states allow DEMs to attend breech births, such as Arizona, California, Minnesota, New Mexico, South Carolina, Tennessee, and Wisconsin. It is not permitted in Alaska, Arkansas, Colorado, Idaho, Louisiana, Montana, New Hampshire, and Texas. Arizona Department of Health Services, Division of Licensing Services, "Midwifery Scope of Practice by State," *http://azdhs.go/als/midwife/documents/committee/additional-resources/state-law-chart-vbac-br-mg.pdf,* accessed 5 August 2013.

166. Some states allow DEMs to attend multiple births, such as California, Minnesota, New Mexico, South Carolina, Tennessee, Texas, and Wisconsin. It is not permitted in Alaska, Arkansas, Arizona, Colorado, Idaho, Louisiana, New Hampshire, and Vermont.

167. Some states allow DEMs to attend VBACs, such as Colorado, Florida, Idaho, New Hampshire, New Mexico, Tennessee, and Utah. It is prohibited in Alaska, Arkansas, and South Carolina. Other states do not impose particular condition-specific limitations but use a risk scoring system. Fla. Admin. Code § 64B24-7.004.

168. Vt. Stat. Ann. tit. 26 § 4190; Fla. Admin Code § 64B24-7.004(1); Minn. Stat. § 147D.05; 22 Tex. Admin.

Code § 831.60.

169. E.g. 16-4000-4106 Del. Code Reg. § 4.3; N.J. Admin. Code § 13:35-2A.6; N.Y. Educ. Code § 6951(1); Tenn. Code Ann. § 63-39-115(a).

170. Voluntary professional organization guidelines in Washington sets out three levels: discussion, consultation, and transfer. Midwives Association of Washington State, "Indications for Discussion, Consultation and Transfer of Care in an Out-of-Hospital Midwifery Practice," April 2008, *http://washingtonmidwives.org/for-midwives/indications-consultation.html,* accessed 9 September 2013.

171. Ariz. Admin. Code § R9-16-109; La. Rev. Stat. §§ 37:3244(b) & 37:3258; S.C. Code Reg. § 24(G)(1).

172. Cal. Bus. & Prof. Code § 2507.

173. 16 Del. Code Reg. 4106. See also *http://www.mommatraumablog.com/1/post/2013/04/freedom-to-safe-birth-options-denied-investigators-visit-delaware-families.html,* accessed 9 September 2013.

174. J. Ecker and H. Minkoff, "Home birth: what are physicians' ethical obligations when patient choices may carry increased risk?" *Obstetrics & Gynecology* 117, no. 5 (May 2011): 1179-82; H. Minkoff and J. Ecker, "A Reconsideration of Home Births in the United States," in this issue of *JCE;* C.L. Wendland, "Exceptional Deliveries: Home Births as Ethical Anomalies in American Obstetrics," in this issue of *JCE.*

175. *http://www.ruralhealthresearch.org/staff/lanzhao/,* accessed 5 August 2013.

176. Cal. Code Reg. tit. 16 § 1379.22.

177. K.M. Happe, "Is California Edging towards a 'Consultive' Relationship between Midwives and Physicians?" *McGeorge Law Review* 32, no. 2 (2000-2001): 713-32.

178. In re Osborn, No. 1999-040052, 1M-98-83794 (Cal. AOH 1999). J.B. White, "California Midwives Push to Scrap Doctor Supervision Requirement for Home Births," *Sacramento Bee,* 8 July 2013.

179. La. S.B. 320 (2012), enacted as La. Act 772, codified at La. Rev. Stat. § 37:3258.

180. Cal. A.B. 1308 (2013) (Bonilla).

181. Del. H.B. 194 (2013) (Barbieri), signed 31 July 2013.

182. B.A. McCormick, "Childbearing and Nurse-Midwives: A Woman's Right to Choose," *New York University Law Review* 58, no. 3 (1983): 661-713.

183. Amnesty International, "Deadly Delivery: The Maternal Healthcare Crisis in the USA," 2010, *http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf,* accessed 29 August 2013.

184. Childbirth Connection, Catalyst for Payment Reform, and Center for Healthcare Quality and Payment Reform, *The Cost of Having a Baby in the United States,* 2013, *http://transform.childbirthconnection.org/wp-content/uploads/2013/01/Cost-of-Having-a-Baby1.pdf,* accessed 29 August 2013.; see also E. Rosenthal, "American Way of Birth, Costliest in the World," *New York Times,* 30 June 2013; and Health Management Associates, "Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits," 31 October 2007, *http://www.washingtonmidwives.org/assets/Midwifery_Cost_Study_10-31-07.pdf,* accessed 29 August 2013.

185. S.K. Hayden, "The Business of Birth: Obstacles Facing Low-Income Women in Choosing Midwifery Care after the Licensed Midwifery Practice Act of 1993," *Berkeley Women's Law Journal* 19, no. 1 (2004): 257-69.

186. Wash. Rev. Code § 48.43.045.

187. Vt. S.B. 15 (2011), enacted at Vt. Act 035, codified as Vt. Stat. Ann. tit. 8 § 4099d.

188. Alaska, Arizona, California, Florida, Idaho, New Hampshire, New Mexico, New York, Oregon, South Carolina, Texas, Vermont, Virginia, Washington. The details of coverage are more complicated than answering a yes/no question. For example, California DEMs qualify for Medicaid coverage only if they satisfy the physician supervision requirement. Since DEMs cannot satisfy this requirement, they do not qualify for Medicaid coverage.

189. Access to Certified Professional Midwives Act of 2013, H.R. 1976, 113th Cong., 1st Sess. (2013) (Pingree). Representative Pingree introduced a similar bill in 2011. H.R. 1054, 112th Cong., 1st Sess. (2011).

190. 42 U.S.C. §§ 1395x(gg) & 1396d(a)(17) (covering "services furnished by a nurse-midwife . . . legally authorized to perform under State law . . . .").

191. Kaiser Family Foundation, "Medicaid Benefits: Nurse Midwife Services," October 2010, *http://kff.org/Medicaid/state-indicator/nurse-midwife-service,* accessed 5 August 2013.

192. Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 3114, codified at 42 U.S.C. § 1395l(a)(1). CMS later implemented this provision. DHHS, "Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011," 75 *Federal Register* 40,039, 40,120, 13 July 2010.

193. American College of Nurse-Midwives, "Health Care Reform," *http://midwife.org/Midwives-and-Medicare-after-Health-Care-Reform,* accessed 5 August 2013.

194. C. Sakala, "U.S. Health Care Reform Legislation Offers Major New Gains to Childbearing Women and Newborns," *Birth* 37, no. 4 (2010): 337-40.

195. S.M. Jenkins, "Medicare and Medicaid Coverage of CPM Services," *NACPM News*, September 2007, *http://www.nacpm.org/nacpm-medicaid-medicare.html,* accessed 5 August 2013.

196. Sec. 2706 of the Affordable Care Act is codified at 42 U.S.C. § 300gg–5 (2010) Non-discrimination in health care. It takes effect 1 January 2014.

197. FAQs about the Affordable Care Act Implementation Part XV, U.S. Department of Labor, 29 April 2013, *http://www.dol.gov/ebsa/faqs/faq-aca15.html,* accessed 5 August 2013.

198. "[S]ection 2706 of the ACA will go into effect in January 2014, barring insurance companies from discriminating against health care providers who are working within the limits of their licenses under current state law." L. Wallis, "Overcoming State Hurdles to Independent NP Practice: Recognition by reimbursement and insurance companies remain key issues," *American Journal of Nursing* 113, no. 3 (March 2013): 16.

199. ". . . Section 2706 would make it illegal for insurers to cover any health service for one class of providers licensed to perform it while rejecting coverage for an-

other also licensed to do so." D. Redwood, "Editor's Log, Provider Nondiscrimination Update," *Health Insights Today,* January/February 2013, *http://www.cleveland.edu/hit/janfeb-2013-vol-6-no-1/editors-log-provider-nondiscrimination-update/,* accessed 5 August 2013.

200. "To the extent CAM practitioners expect Section 2706 to increase insurance coverage for their services or increase reimbursement, yes that will likely happen to a certain extent. And of course the ACA greatly increases the number of insured people. But I don't expect it to be quite the boon they seem to be expecting." J. Bellamy, "Obamacare and CAM II: Discrimination (or not) against CAM," *Science-Based Medicine,* 4 October 2012, *www.sciencebasedmedicine.org/23031/,* accessed 5 August 2013.

201. See FAQs about the Affordable Care Act Implementation Part XV, note 197 above.

202. *Charting a Course for the 21st Century: The Future of Midwifery* (San Francisco, Calif.: Pew Health Professional Commission and University of California, 1999); U.S. Congress, Office of Technology Assessment, *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis* (Washington, D.C.: U.S. Government Printing Office, December 1986), *http://ota-cdn.fas.org/reports/8615.pdf,* accessed 16 August 2013; American Public Health Association, "Increasing Access to Out-of-Hospital Maternity Care Services through State-Regulated, Nationally-Certified Direct Entry Midwives, Resolution Adopted by the Governing Council," 2001, *http://www.apha.org/advocacy/policy/policysearch/default.htm?id=242,* accessed 5 August 2013.

203. See MacDorman, note 4 above; S. Coburn, "Obstructed Birth: Racism in Midwifery Regulation: The Emergence of the CPM and the Need for Movement Building," *http://lsrj.org/documents/awardsgrants/11_LSRJ_Writing_Prize_Sarah_Coburn.pdf,* accessed 5 August 2013.

204. Institute of Medicine, *Future of Nursing: Leading Change, Advancing Health* (Washington, D.C.: National Academies Press, 2011).