THE CORONAVIRUS AS A CHANGEMAKER: OPPORTUNITIES TO ADVANCE AMERICAN MATERNAL CARE IN THE WAKE OF THE PANDEMIC

RACHEL ANDERSON-SELLER*

Abstract

Birthing people in the United States pay more than citizens of other high-income countries and receive lower quality care, most of which is provided by physicians in hospital settings. Legal restrictions on midwives—the result of two centuries of pervasive sexist, racist, and anti-immigrant campaigns—prevent birthing people from making meaningful choices about their preferred birthing location and attendant, even though hospital births carry risks of their own. Policymakers may be hesitant to amend legislation and regulations due to a misperception that community birth is unsafe and that those who choose it are irresponsible. However, the COVID-19 pandemic presents an opportunity for change. In an effort to avoid hospitals, which are overwhelmed with COVID-19 patients and have enacted strict limits on support personnel during labor, birthing women are increasingly turning to community birth. Midwives and their clients can capitalize on this increased demand by advocating for an updated maternal care system.

INTRODUCTION

In February 2020, the National Academies of Sciences, Engineering, and Medicine released a landmark 352-page report entitled *Birth Settings in America: Outcomes, Quality, Access, and Choice* (hereinafter, "National Academies Report").[1] The National Academies

* J.D. Candidate 2022, Columbia Law School; B.S. 2011, United States Military Academy. Many thanks to Professor Elizabeth Emens for her helpful guidance, as well as to the staff of the *Columbia Journal of Gender and Law* for their insightful comments and edits. This one's for you, Mom.

[1] COMM. ON ASSESSING HEALTH OUTCOMES BY BIRTH SETTINGS, NAT'L ACADS. OF SCIS., ENG'G, AND MED., BIRTH SETTINGS IN AMERICA: IMPROVING OUTCOMES, QUALITY, ACCESS, AND CHOICE (Susan C. Scrimshaw & Emily Backes eds., 2020) [hereinafter NAT'L ACADS. REP.].

Report, requested by the bipartisan Congressional Caucus on Maternity Care,[2] found that many women[3] do not have meaningful access to choice in birth setting.[4] No birth, whether it takes place in a hospital, a freestanding birth center,[5] or at home, is risk-free.[6] However, women are prevented from assessing the various risks associated with each birthing location and then using that assessment to make their own informed decisions when their insurance restricts access to providers who practice outside of hospitals,[7] or when their state law criminalizes the providers who would attend a community[8] birth.[9]

Later that same month, scientists began issuing ominous warnings of the new coronavirus, which was first discovered in China and began spreading during winter 2019.[10] By March, the disease had arrived in full-force, and hospitals began to prepare for the impact. Hospitals' actions had direct consequences for pregnant and laboring women. Some hospitals completely shut down maternity wards in order to save space for COVID-

[2] *Id.* at 19.

[3] Although the vast majority are, not all parturients or midwives are women. Men can be midwives—the "wife" in midwife refers to the woman giving birth, not the woman assisting—and transgender men or non-binary people can give birth. This Note refers often to birthing people and midwives as women and uses she/her pronouns, especially in Part I, not to dismiss the experiences of male midwives or of pregnant people who do not identify as women, but to draw attention to the gender dynamics often present as predominantly male physicians have sought to control the birthing process.

[4] NAT'L ACADS. REP., *supra* note 1, at 12.

[5] A freestanding birth center is a facility separate from a hospital where care is provided under the midwifery model. Although some hospitals refer to their specialty maternity wards as birth centers, this Note uses the term to refer only to freestanding centers. *See* NAT'L ACADS. REP., *supra* note 1, at 58.

[6] NAT'L ACADS. REP., *supra* note 1, at 12.

[7] *Id.* at 7. Private insurance and Medicaid both restrict access to community birth options. *See infra* Section II.C.1.

[8] This Note uses the term "community birth," as opposed to "out-of-hospital birth," to identify births that occur in birth centers and homes, in order to avoid reinforcing hospital-based birth as the norm. *See* Melissa Cheyney et al., *Community Versus Out-of-Hospital Birth: What's in a Name?*, 64 J. MIDWIFERY & WOMEN'S HEALTH 9, 9 (2019).

[9] NAT'L ACADS. REP., *supra* note 1, at 81.

[10] James Hamblin, *You're Likely to Get the Coronavirus*, THE ATLANTIC (Feb. 25, 2020, 7:43 PM), https://www.theatlantic.com/health/archive/2020/02/covid-vaccine/607000/ [https://perma.cc/L4JY-XL38].

19 patients.[11] Others encouraged women to induce labor at thirty-nine weeks in a counterproductive effort to speed up birth (women whose labor is induced tend to spend *more* time in the hospital).[12] Still others forced women to give birth alone—only revising their policies after receiving a governor's executive order[13]—or forcibly separated women from their newborns. LaToya Jordan of Brooklyn gave birth in Long Island's NYU Winthrop Hospital on March 30, 2020.[14] After she arrived to the hospital with a cough, the hospital tested her for COVID-19 and then immediately separated her from her husband for the duration of her labor.[15] When her daughter was born, Ms. Jordan was not allowed to touch the baby or even remain in the same room with her.[16]

In response to these draconian restrictions and out of fear of contracting the virus itself, women began looking to home birth.[17] However, many states do not offer licenses to the midwives who would typically attend a home birth.[18] In those states that do not offer licenses, midwives are subject to criminal prosecution,[19] and families who wish to birth with a midwife at home have no method of verifying the midwife's training and

[11] Eileen Guo, *Coronavirus Threatens an Already Strained Maternal Health System*, N.Y. TIMES (Mar. 26, 2020), https://www.nytimes.com/2020/03/26/us/coronavirus-pregnancy-maternal-health-system.html [https://perma.cc/X3QS-7SJL].

[12] *Id.*

[13] Katie Van Syckle & Christina Caron, *'Women Will Not Be Forced to Be Alone When They Are Giving Birth,'* N.Y. TIMES (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/parenting/nyc-coronavirus-hospitals-visitors-labor.html [https://perma.cc/6WCQ-7LFV].

[14] Irin Carmon, *'They Separated Me from My Baby,'* THE CUT (Apr. 7, 2020), https://www.thecut.com/2020/04/coronavirus-newborns-hospitals-parents.html [https://perma.cc/4HDZ-QYE2].

[15] *Id.*

[16] *Id.*

[17] Kimiko de Freytas-Tamura, *Pregnant and Scared of 'Covid Hospitals,' They're Giving Birth at Home*, N.Y. TIMES (Apr. 24, 2020), https://www.nytimes.com/2020/04/21/nyregion/coronavirus-home-births.html [https://perma.cc/7SUE-D83Z].

[18] *Legal Recognition of CPMs,* NAT'L ASS'N OF CERTIFIED PRO. MIDWIVES (May 15, 2020), https://nacpm.org/about-cpms/who-are-cpms/legal-recognition-of-cpms/ [https://perma.cc/RG2S-TJWZ].

[19] Tyler Pager, *She Helped Deliver Hundreds of Babies. Then She Was Arrested.*, N.Y. TIMES (Mar. 5, 2019), https://www.nytimes.com/2019/03/05/nyregion/mennonite-midwife-arrest.html [https://perma.cc/P5DS-6QCG].

credentials.[20] Even in the states that do offer licenses, many do not authorize midwives to practice autonomously, which has the practical effect of restricting them to hospital settings.[21]

Since the mid-18th century, physicians have been consolidating power at the expense of midwives and the women they serve.[22] The United States has one of the highest levels of neonatal[23] and maternal[24] mortality of any high-resource country, even though the U.S. spends more than any other country on childbirth.[25] Women have been engaging in a concerted effort since the mid-20th century to bring birth back to the community and reclaim their autonomy in the birthing process,[26] but they have encountered many roadblocks along the way. The shift to hospital birth and the legal barriers to physiologic

[20] Neil Vigdor, *Unlicensed Nebraska Midwife Is Arrested in Newborn's Death After Home Delivery*, N.Y. TIMES (July 6, 2019), https://www.nytimes.com/2019/07/06/us/nebraska-midwife.html [https://perma.cc/7EEC-UYY9].

[21] *See* NAT'L ACADS. REP., *supra* note 1, at 69.

[22] *See infra* Section I.B–C.

[23] Irene Papanicolas et al., *Health Care Spending in the United States and Other High-Income Countries*, 319 J. AM. MED. ASS'N 1024, 1028 (2018).

[24] Roosa Tikkanen et al., *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, THE COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/LFT2-KGP6].

[25] Niall McCarthy, *The U.S. is the World's Most Expensive Nation for Childbirth*, FORBES (Jan. 29, 2020, 6:28 AM), https://www.forbes.com/sites/niallmccarthy/2020/01/29/the-us-is-the-worlds-most-expensive-nation-for-childbirth-infographic [https://perma.cc/6SUU-FFPB].

[26] *See generally* WENDY KLINE, COMING HOME: HOW MIDWIVES CHANGED BIRTH (2019).

birth[27] in a community setting are well-documented.[28] This Note seeks to provide state-specific context for those barriers, which have persisted despite evidence that hospital birth is not necessarily superior, and presents the COVID-19 pandemic as a watershed moment that can and must lead to wide reform.

This Note begins in Part I by detailing the history of childbirth in the United States as well as the social and legal factors that contributed to its transition from the home, under the care of a midwife, to the hospital, attended primarily by physicians. Part II continues with modern definitions of midwifery credentials, an explanation of the benefits of midwifery care and community birth, and the obstacles that birthing people face in securing a community birth for themselves. Each state has its own unique history of midwives and the efforts to regulate them. Part III of this Note presents a close look at the recent history of regulation in four states, selected for their diversity of regulatory schemes and populations. Part IV explains how circumstances have changed due to the COVID-19 pandemic and how this can be an opportunity for midwives and their supporters to increase access to midwifery care.

I. History of American Birth: From Home to Hospital and (Somewhat) Back Again

Giving birth in a hospital is a relatively recent phenomenon. Before the 18th century, virtually all babies were born at home, with midwives or female friends and family members in attendance, and homes remained the dominant birthing location in the United States until the 20th century. Part I chronicles the shift from the home into the hospital as well as more recent efforts to bring birth back into the community.

---

[27] Physiologic birth is defined as "one that is powered by the innate human capacity of the woman and fetus." Am. Coll. Of Nurse-Midwives et al., *Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by the American College of Nurse-Midwives, Midwives Alliance of North America, and the National Association of Certified Professional Midwives*, 57 J. MIDWIFERY & WOMEN'S HEALTH 529, 529 (2012). This is sometimes referred to as "natural" childbirth. This Note uses the term "physiologic birth" because the definition of natural birth has evolved to mean anything from birth without the use of pain medication to all vaginal births.

[28] *See, e.g.,* Stacy A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61 (2004); Suzanne Hope Suarez, *Midwifery Is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315 (1993).

A. Childbirth in Colonial America and the Early United States

Until relatively recently, pregnancy and childbirth tended to dominate women's lives. White American women gave birth to seven live children, on average, at the beginning of the 19th century, and rates remained this high throughout the century for women of color and immigrant women.[29] Pregnancy and childbirth were dangerous and took both a physical and psychological toll on women.[30] Women took for granted that a pregnancy could very well end in the death of their child, themselves, or both. In 1852, one woman kept a journal once she discovered she was pregnant so that her child would have a way to remember her, should she die giving birth.[31] Even women who survived often had to deal with permanent physical limitations that resulted from injuries sustained in childbirth.[32]

Prior to 1760, white women in the North exercised considerable control over the physical location and attendees of the birth itself.[33] Childbirth was a social event, with a midwife and sometimes a large circle of friends in attendance.[34] Midwives generally played a supportive role in the process, spending most of their time waiting and encouraging the birthing woman, although they did have some mild means of intervention in cases of particularly long labors.[35] In cases where a midwife did need to call a physician, it was not to assist with a live birth, but to dismember and extract the fetus in an effort to save the mother.[36] Although women gained strength from the presence of their friends who had

---

[29] *See* JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA, 1750-1950, at 14 (1986).

[30] These physical realities of pregnancy and childbirth were used to justify confining women to the domestic realm. *Id.*

[31] *Id.* at 21.

[32] *Id.* at 29.

[33] Although it is important to note that women's experiences varied according to their race, along with wealth and immigrant status, a detailed discussion of the impact of race (and with it, enslavement) is outside the scope of this Note. For a thoughtful and thorough discussion of the topic, please *see* Danielle Thompson, *Midwives and Pregnant Women of Color: Why We Need to Understand Intersectional Changes in Midwifery to Reclaim Home Birth*, 6 COLUM. J. RACE & L. 27 (2016).

[34] WALZER LEAVITT, *supra* note 29, at 37. For reasons of modesty, men were not present at births.

[35] *Id.* at 38.

[36] Helen Varney & Joyce Beebe Thompson, A HISTORY OF MIDWIFERY IN THE UNITED STATES: THE MIDWIFE SAID FEAR NOT 9 (2016).

successfully endured childbirth, high mortality rates made it a fearful event, and women with the economic means to do so began to explore options for a safer or less painful birth.[37]

B. Men Enter the Birthing Room, and the Move to the Hospital

The first man-midwives—the ancestors of today's obstetric physician—in the United States were wealthy men who had the means to study medicine in Great Britain.[38] Physicians occupied a high social rank due to their gender and perceived superior education, although in reality most American doctors had been trained through apprenticeship, just like the midwives.[39] In the South, the physicians' whiteness also contributed to their "legitimacy."[40] To the woman eager to have a less painful and fearful birth, the physician could argue that he was a better choice over the midwife because of his training in anatomy and in the use of forceps.[41] The dichotomy between the medical model and midwifery models of childbirth was evident immediately. Unlike the observational midwife, physicians felt compelled to intervene in the process.[42]

After men were welcomed into the birthing room by women seeking a safer delivery, women also began to move to the hospital in search of a pain-free delivery. "Twilight sleep" was a method developed in Freiburg, Germany in the early 20th century, which involved injecting women with scopolamine and morphine at the onset of labor.[43] If the procedure was successful, the drugs would put her into a state of semi-consciousness, and although she experienced pain, she would have no memory of it.[44] The procedure was

---

[37] WALZER LEAVITT, *supra* note 29, at 38.

[38] Varney & Beebe Thompson, *supra* note 36, at 23.

[39] WALZER LEAVITT, *supra* note 29, at 39.

[40] Tanfer Emin Tunc, *The Mistress, the Midwife, and the Medical Doctor: Pregnancy and Childbirth on the Plantations of the Antebellum American South, 1800–1860*, 19 WOMEN'S HIST. REV. 395, 405 (2010).

[41] Varney & Beebe Thompson, *supra* note 36, at 24.

[42] SALLY G. MCMILLEN, MOTHERHOOD IN THE OLD SOUTH: PREGNANCY, CHILDBIRTH, AND INFANT REARING 9 (1990).

[43] Judith Walzer Leavitt, *Birthing and Anesthesia: The Debate over Twilight Sleep*, 6 Signs: J. Women in Culture & Soc'y 147, 149 n.9, 150 (1980).

[44] There was a higher success rate for wealthy women, who could afford to birth in a private room. For women who had to give birth in an open ward, the screams of their fellow laboring mothers often prevented them from achieving the sought-after semi-consciousness. Varney & Beebe Thompson, *supra* note 36, at 44.

relatively dangerous, and one quarter of babies required resuscitation.[45] Twilight sleep and its promise of "painless" childbirth became a feminist issue, and the media blamed physicians, who were slow to adopt the procedure in America for reasons of safety, for cruelly withholding it.[46]

Physicians eventually acceded to the demands in what would prove to be a turning point for physician-controlled childbirth and the elimination of the midwife, who had no access to the drugs or medical training required to administer the twilight sleep cocktail. The women who had demanded control and the power to choose a painless hospital birth were presented with a cruel irony. As they entered the hospitals, they were separated from family, strapped down, and, once unconscious, subject to whatever instruments the physician chose to use to deliver the baby.[47] The hospital was the domain of the physician, not the birthing woman.

C. The Midwife Problem and Professionalization of the Midwife

Although women of means had voluntarily turned to physicians and hospitals promising safe and painless childbirth, midwives still attended the births of immigrant women, Black women, and others who could not afford a physician-attended hospital birth. At the turn of the 20th century, maternal and infant mortality remained high, but they began to be seen as solvable problems rather than unfortunate facts of life. This, coupled with physicians' desire to elevate the status of obstetrics and secure clinical experience for medical students, was the core of the so-called "midwife problem."[48] Physicians would never receive the respect they desired if their work could be performed by ordinary women, who often spent much more time with the birthing mother for much less money.[49] Though physicians generally achieved outcomes that were no better than those of midwives, and even admitted as much to each other, they were able to use the high mortality rate to

[45] *Id.* at 44.

[46] *Id.* at 46.

[47] *Id.* at 48.

[48] *Id.* at 34.

[49] *Id.* at 36 (quoting Joseph B. De Lee, prominent Chicago physician, in his 1914 speech to his colleagues: "Do you wonder that a young man will not adopt this field as his special work? If a delivery requires so little brains and skill that a midwife can conduct it, there is not the place for him.").

advocate for—and achieve—the regulation of midwives, with the intent that such regulation would eventually lead to their abolition.[50]

Midwifery was ultimately saved when it joined itself to the nursing profession, although the effect of this alliance was the further marginalization of Black, Brown, immigrant, and other midwives directly connected to the communities they served, as they were replaced with a predominantly white nurse-midwife corps.[51] Federal legislation in the form of the National Maternity and Infancy Protection Act ("Sheppard-Towner Act") contributed heavily to this shift.[52] The Sheppard-Towner Act's 1921 passage as the first federal social security law was a direct result of the full enfranchisement of women[53] achieved the year before.[54] Under the Act, states received matching federal funds for maternity and infant health programs,[55] and many states used these funds to launch registration and education campaigns for midwives[56] and to employ nurses as midwife supervisors.[57] In 1925, the Department of Labor reported positively that the campaigns were having a notable impact on the goal of reducing the percentage of births attended by midwives.[58] However, the Sheppard-Towner Act faced substantial anti-socialist and anti-feminist backlash from the American Medical Association, among others, and the law

[50] *Id.* at 37.

[51] Katy Dawley, *Origins of Nurse-Midwifery in the United States and its Expansion in the 1940s*, 48 J. MIDWIFERY & WOMEN'S HEALTH 86, 87 (2003).

[52] *See generally* Johana-Marie E. L. K. Williams, *The Midwife Problem: The Effect of the 1921 Sheppard-Towner Act on Black Midwives in Leon County* (Feb. 7, 2014) (unpublished conference paper), https://www.researchgate.net/publication/319631627_The_Midwife_Problem_The_Effect_of_the_1921_Sheppard-Towner_Act_on_Black_Midwives_in_Leon_County [https://perma.cc/HK6N-ME64].

[53] The author recognizes that Black Southern women and other women of color would have continued to face barriers to voting, despite the ratification of the 19th Amendment.

[54] J. Stanley Lemons, *The Sheppard-Towner Act: Progressivism in the 1920s*, 55 J. AM. HIST. 776, 777 (1969).

[55] Sheppard-Towner Act, ch. 135, § 2, 42 Stat. 224 (1921) (expired in 1929).

[56] CHILD.'S BUREAU, DEP'T OF LAB., BUREAU PUB. NO. 156, THE PROMOTION OF THE WELFARE AND HYGIENE OF MATERNITY AND INFANCY 12 (1926).

[57] *Id.* at 26 (Colorado), 25 (Arkansas), 48 (New York).

[58] *Id.* at 12.

lapsed in 1929 (although many states maintained the programs they had begun under the Act, and similar legislation was incorporated into the New Deal).[59]

Nurse-midwifery grew out of the same concern for maternal and infant health that led to the Sheppard-Towner Act, with nurse-midwives joining the obstetricians' campaign to eliminate traditional midwives based on their perceived lack of skill.[60] Mary Breckinridge was an American nurse who volunteered in France after the end of World War I and observed the quality care that European nurse-midwives provided their clients.[61] She was able to obtain a place in an English midwifery school and returned to the United States in 1925 as a certified midwife, where she campaigned to bring nurse-midwifery services first to rural Appalachia, then to the United States as a whole.[62] Nurse-midwifery expanded after World War II due to both a boom in hospital construction, which led to a shortage of obstetricians to staff the hospitals, and to third-party health insurance, which made hospital birth more financially accessible.[63]

D. Bringing Birth Back Home

Before the present pandemic-inspired surge in demand for community birth attended by midwives, community birth, and home birth in particular, experienced two brief periods of increase. First, the counterculture movement of the 1960s and 70s inspired women to challenge the norm of the medical model of birth.[64, 65] Whereas families had previously looked to midwives out of necessity, because they could not afford a physician's fees, or because there was no local hospital, the women seeking community birth during this era were economically privileged.[66]

---

[59] Lemons, *supra* note 54, at 784-86.

[60] Dawley, *supra* note 51, at 92.

[61] *Id.* at 88.

[62] *Id.*

[63] *Id.* at 89.

[64] *See infra* Section II.B.1.

[65] *See generally* KLINE, *supra* note 26.

[66] William Scott, *Lay Midwives: Some Solutions to a Serious Problem*, 16 CONTEMP. OB/GYN 37 (1980).

Later, in the early-mid 2000s, home birth became a status symbol for middle-class and wealthy white women; the New York Times even ran a feature on midwives in the Fashion section.[67] In 2008, Ricki Lake released her documentary "The Business of Being Born," which featured footage of home births, including Ms. Lake's, juxtaposed with statistics on the intervention rates associated with hospital births.[68] Its follow-up, released in 2011, featured testimonies from celebrities such as Gisele Bündchen, Alanis Morissette, Christy Turlington, and Laila Ali.[69] The original film became an underground hit and was credited with inspiring a run on home birthing pools.[70] As in the 1960s and 1970s, the women who planned these home births generally could not rely on insurance and had to be well-off enough to afford the out-of-pocket costs associated with the birth.[71] Although community birth has continued to grow, by 2019 the rate of growth had leveled off from its peak in 2007–2014.[72]

II. Modern Midwifery Practice

In order to remove the barriers to physiologic birth in a community setting, it is important to understand what those barriers are and why they matter. Part II proceeds in four sections. Section II.A defines the various categories of midwife and the credentials that a midwife may hold. Section II.B explains critical differences between care provided by physicians in hospitals and care provided by midwives and why women should be given access to midwifery care. Section II.C shows how the current regulatory structure present in many states prevents women from giving birth in the setting of their choice. Section II.D provides examples of two regulatory structures that do allow women to exercise choice in their birthing location.

---

[67] Danielle Pergament, *The Midwife as Status Symbol*, N.Y. TIMES (June 15, 2012), https://www.nytimes.com/2012/06/17/fashion/the-midwife-becomes-a-status-symbol-for-the-hip.html [https://perma.cc/M5Q5-RB6Q].

[68] THE BUSINESS OF BEING BORN (New Line Home Entertainment 2008).

[69] MORE BUSINESS OF BEING BORN (First Look Pictures 2011).

[70] Julie Scelfo, *Baby, You're Home*, N.Y. TIMES (Nov. 13, 2008), https://www.nytimes.com/2008/11/13/health/13iht-13birth.17787927.html [https://perma.cc/G9DY-8RLV].

[71] Marian MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 279 (2019).

[72] NATALITY, 2007–2020 RESULTS, CDC WONDER (Jan. 28, 2021, 2:08 PM), https://wonder.cdc.gov/controller/saved/D66/D108F166 [https://perma.cc/R2MZ-WTF6] (click "I Agree" to access data).

A. Midwives and Their Practices

The debate surrounding midwives is complicated by the numerous and often overlapping terms that can be used to describe a midwife and her credentials. Midwives can be broken down broadly into two categories: certified nurse-midwives (CNMs)/certified midwives (CM) and certified professional midwives (CPM)/lay midwives. All midwives attend to women in normal childbirth,[73] but they differ in their education and in their scopes and locations of practice.

1. Certified Nurse-Midwives (CNM) and Certified Midwives (CM)

Certified nurse-midwives are advanced practice nurses. CNMs have a bachelor's degree in nursing, a registered nurse license, and a nurse-midwifery graduate degree.[74] All fifty states license CNMs, and each state regulates its CNMs differently.[75] Because of the restrictions placed on CNMs, who are often required to practice under the supervision of a physician, as well as the hospital-based nature of their training, CNMs attend births primarily in hospitals.[76] Certified midwives (CM) have a bachelor's degree in a non-nursing subject and then go on to earn a master's degree in midwifery.[77] CMs are licensed in nine states: Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, and Virginia.[78]

---

[73] The World Health Organization defines "normal childbirth" as "spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between thirty-seven and forty-two completed weeks of pregnancy. After birth mother and infant are in good condition." Dep't of Repro. Health & Rsch, World Health Org. [WHO], *Care in Normal Birth: A Practical Guide*, at 4, WHO Doc. 96.24 (1996).

[74] *Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S.*, AM. COLL. OF NURSE-MIDWIVES (Oct. 2017), https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf [https://perma.cc/5TAT-FQET].

[75] *Id.*

[76] *See* MacDorman & Declercq, *supra* note 71, at 283.

[77] AM. COLL. OF NURSE-MIDWIVES, *supra* note 74, at 4.

[78] *The Credential CNM and CM*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/The-Credential-CNM-and-CM [https://perma.cc/7YB5-78SX].

Aside from the CNM's nursing background, CNMs and CMs have the same qualifications.[79] Both receive board certification from the American Midwifery Certification Board (AMCB), meet the same core competencies, and have the same scopes of practice.[80] CNMs and CMs practice evidence-based care.[81] They recognize pregnancy and birth as normal physiological processes and do not intervene except in the case of complications.[82] They are trained in the full spectrum of women's reproductive health, from managing miscarriages to treating sexually transmitted infections and providing medical abortions where state law allows.[83] CNMs and CMs have also specifically committed to providing care for transgender and gender non-conforming people who do not identify as women.[84] During birth, midwives facilitate the process of physiologic labor in several ways, including by providing emotional and social support, and are trained to identify circumstances that may require additional intervention.[85]

2. Certified Professional Midwives (CPM) and Lay Midwives

CPMs and lay midwives[86] attend births primarily in homes and birth centers.[87] The CPM certification is a credential developed by the North American Registry of Midwives,

---

[79] *Certified Midwife Credential*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/certified-midwife-credential [https://perma.cc/V7RY-6ADS].

[80] *Id.*

[81] *ACNM Core Competencies for Basic Midwifery Practice,* AM. COLL. OF NURSE-MIDWIVES 3 (Mar. 20, 2020), http://midwife.org/acnm/files/acnmlibrarydata/uploadfilename/000000000050/ACNMCoreCompetenciesMar2020_final.pdf [https://perma.cc/29NR-GYS2].

[82] *Id.*

[83] *Id.* at 6-7.

[84] *Id.* at 2.

[85] *Id.* at 8.

[86] This Note uses the term "lay midwife" to refer to midwives who do not have CNM, CM, or CPM credentials and are not licensed by the state. Some states, however, use the term to refer to all direct-entry midwives and do provide these midwives a path to licensure. *See, e.g.*, ARK. CODE ANN. § 17-85 (2019).

[87] AM. COLL. OF NURSE-MIDWIVES, *supra* note 74, at 3.

and it is the only midwifery credential that requires out-of-hospital experience.[88] Before an applicant is certified, she must have attended a minimum of fifty births and have conducted one hundred prenatal and forty infant exams.[89] CPMs possess at least a high school diploma and must either complete an apprenticeship or have graduated from a program accredited by the Midwifery Education Accreditation Council (MEAC) before sitting for a written examination.[90] Because only the MEAC route meets the International Confederation of Midwives (ICM) standard for education, the US Midwifery Education, Regulation, and Association (U.S. MERA) coalition encourages states to require new CPMs to have completed a MEAC-accredited program.[91]

CMs, CPMs, and lay midwives are considered direct-entry midwives (DEM) because they do not have prior nursing training.[92] Like CNMs and CMs, CPMs recognize pregnancy and birth as normal physiological processes.[93] CPMs are also qualified to manage normal birth and identify deviations that would require intervention.[94] CNMs, CMs, and CPMs are similarly competent to provide care during pregnancy, birth, and the postpartum period. However, while the care that CNMs and CMs provide may begin in adolescence and extend beyond menopause, CPMs are limited to caring for women in the immediate period surrounding pregnancy.[95]

---

[88] A CNM or CM with community birth experience may also be awarded the credential, but in this Note the term CPM solely refers to midwives without CNM or CM certifications. *See* N. AM. REGISTRY OF MIDWIVES, CANDIDATE INFORMATION BOOKLET 6 (2020).

[89] *Id.* at 8–9.

[90] *Id.* at 8–10.

[91] *See Statement on the Licensure of Certified Professional Midwives,* U.S. MIDWIFERY EDUC., REGUL., & ASS'N (July 1, 2015), http://www.usmera.org/index.php/2015/07/01/statement-on-the-licensure-of-certified-professional-midwives-cpm/ [https://perma.cc/XZ3T-2BJB].

[92] N. AM. REGISTRY OF MIDWIVES ET AL., CERTIFIED PROFESSIONAL MIDWIVES IN THE UNITED STATES 2 (June 2008), https://mana.org/pdfs/CPMIssueBrief.pdf [https://perma.cc/D3D3-GER2].

[93] MIDWIVES ALL. OF N. AM., THE MIDWIVES ALLIANCE CORE COMPETENCIES 1 (Dec. 2014), https://mana.org/sites/default/files/pdfs/MANACoreCompetenciesFINAL.pdf [https://perma.cc/XK2N-VGGU] (listing core competencies for all types of midwives).

[94] *Id.*

[95] AM. COLL. OF NURSE-MIDWIVES, *supra* note 74, at 3.

B. The Hospital and Community Birth Experiences

This section outlines the differences between care provided in hospitals and care provided in a community setting, whether that care is provided in a freestanding birth center or in the home. This section then explains why women should have the option to give birth in a community setting.

1. Models of Maternity Care

In 1979, sociologist Barbara Katz Rothman was the first to formally separate maternity care into the medical and midwifery models.[96] She chose these terms because she found that the care models differed based on the provider rather than the birth setting: midwives brought their model of care into the hospital, and physicians who attended home births still practiced the medical model.[97]

According to Rothman, the medical model of health has its roots in two ideologies. The first conceptualizes the body as a piece of technology, originally as a machine and now as a computer program. As Rothman summarizes the ideology, "[p]roblems in the body are technical problems requiring technical solutions, whether it is a mechanical repair, chemical rebalancing, or 'debugging' the system."[98] The second is the ideology of the patriarchy: medicine is historically a men's profession, and the male body is taken as the norm.[99] Together, these two ideologies contribute to the view that pregnancy and childbirth must be treated as a disease.[100] In the early 1900s, Dr. Joseph B. De Lee, one of the most influential proponents of the view that pregnancy and birth should be treated as pathologies, suggested that labor was a dangerous event that crushed the baby's head and was responsible for conditions such as epilepsy, cerebral palsy, and "imbecility."[101] As the

---

[96] *See* Barbara Katz Rothman, Two Models of Maternity Care: Defining and Negotiating Reality (June 1979) (Ph.D. dissertation, New York University) (ProQuest).

[97] WENDY SIMONDS ET AL., LABORING ON: BIRTH IN TRANSITION IN THE UNITED STATES (2006).

[98] *Id.* at 7.

[99] *Id.* at 7–8.

[100] *Id.* at 8.

[101] *Id.* at 16.

profession of obstetrics developed, labor became something to be managed, and physicians believed their interventions were reasonable responses to the demands of labor.[102]

In modern, practical terms, the medical model of care is often concerned with numbers: what falls within the "normal" range, is the woman in that range, and if not, how should medical professionals intervene? Physicians prescribe a specific range of weight a pregnant woman should seek to gain,[103] and monitor her labor for specific rates of "progress."[104] Interventions often happen in a chain, one leading to the next.[105]

As explained in the National Academies Report, a hospital birth experience is heavily dependent on the particular care provider, the assigned nurse (and the number of patients the nurse is responsible for), and local hospital policies, making it difficult to describe a typical hospital birth.[106] Some people are able to labor, deliver, and recover all in the same room, while others do each of these in a separate space, especially if delivering via cesarean section.[107] Availability of comfort measures, such as tubs or birthing balls, staff doulas, and methods of fetal monitoring that allow women to ambulate during labor also vary by hospital.[108] Rates of intervention, including labor induction, epidurals, artificial rupture of

---

[102] *Id.*

[103] *See* AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, WEIGHT GAIN DURING PREGNANCY, COMMITTEE OPINION NO. 548 (2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/01/weight-gain-during-pregnancy [https://perma.cc/7HFN-LK2P].

[104] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY, OBSTETRIC CARE CONSENSUS NO. 1 (2019), https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery [https://perma.cc/A9RC-L988]. Note that these guidelines represent the first update to the definition of labor dystocia—or "stuck" labor—in sixty years. The original labor curve was drawn by hand, using no mathematical model, yet was relied upon by obstetricians to determine whether their patients should deliver by cesarean section. Jun Zhang et al., *Statistical Aspects of Modeling the Labor Curve*, 212 AM. J. OBSTETRICS & GYNECOLOGY 750, 750 (2015).

[105] SIMONDS ET AL., *supra* note 97, at 66 (noting that the practice of rupturing membranes, a very common intervention performed with the intention of speeding up labor, often leads to even further interventions to speed up labor because once membranes are ruptured, extended labor can be dangerous due to the increased risk of infection).

[106] NAT'L ACADS. REP., *supra* note 1, at 56.

[107] *Id.* at 56–57.

[108] *Id.* at 56.

membranes (breaking the water), and limiting oral intake vary widely among hospitals.[109] Officially, the American College of Obstetrics and Gynecology (ACOG) supports a low-intervention approach,[110] but most hospitals employ interventions at a high rate, even with low-risk laboring women.[111] After birth, availability of lactation consultants or other breastfeeding support similarly varies.[112]

In contrast to the medical model, midwives consider pregnancy and birth to be normal processes that technology cannot generally improve upon.[113] Midwives seek to minimize technological interventions.[114] Midwives, especially when practicing in a community setting, tend to be more patient and allow the birth to progress on its own.[115] Prenatal midwifery care is hands-on, and midwives focus on developing a relationship with their clients so that birthing mothers can feel empowered throughout the process of pregnancy and childbirth.[116] In contrast to the medical model, under which physicians shoulder responsibility for this process, midwives serve primarily as a guide or coach for the birthing person, who is empowered to make key choices throughout the process.[117]

Midwives, who attend the vast majority of births at home and in birth centers, are generally present for the duration of labor, and in ideal situations they simply observe the birth, offering encouragement and reminders to relax and breathe.[118] Birth centers generally

---

[109] *Id.*

[110] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, APPROACHES TO LIMIT INTERVENTION DURING LABOR AND BIRTH, COMMITTEE OPINION NO. 766 (Feb. 2019), https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth.pdf [https://perma.cc/N494-UZ9T].

[111] Lisbet S. Lundsberg et al., *Low-Interventional Approaches to Intrapartum Care: Hospital Variation in Practice and Associated Factors*, 65 J. MIDWIFERY & WOMEN'S HEALTH 33, 33 (2020).

[112] NAT'L ACADS. REP., *supra* note 1, at 57.

[113] SIMONDS ET AL., *supra* note 97, at 38.

[114] MIDWIVES ALL. OF N. AM., *supra* note 93, at 1.

[115] SIMONDS ET AL., *supra* note 97, at 67.

[116] MIDWIVES ALL. OF N. AM., *supra* note 93, at 2.

[117] SIMONDS ET AL., *supra* note 97, at 54.

[118] Lauren Valenti, *Midwives Explain What a Home Birth Really Means*, VOGUE (Apr. 16, 2020), https://www.vogue.com/article/what-is-a-home-birth-is-midwives-guide [https://perma.cc/TZ4A-J8RG].

encourage walking and eating as tolerated, have birthing balls or tubs available for comfort, and offer nitrous oxide or acupressure for pain management.[119] Community midwives are generally able to directly address first-line complications such as maternal hemorrhage or resuscitation of an infant and can arrange for transfer to a hospital if necessary.[120] Hospital transfers for emergency reasons are rare.[121] After birth, the midwife helps the new mother and her baby establish breastfeeding.[122] After discharge, in the case of birth centers, or birth, in the case of home births, midwives generally visit the new family at their home twenty-four hours after birth and again three days later.[123]

2. Reasons for Increasing Access to Community Birth

One reason to increase access to community birth is economic; states could save substantial sums of money by making community birth more accessible. Birth in the United States is expensive, and interventions increase the cost even further. In 2010, total payments for vaginal birth were $18,329 on average for a privately insured birth and $9,131 for a birth covered by Medicaid.[124] Payments for cesarean births were 50% higher.[125] These cost figures include all births across all settings, but because American births take place predominantly in hospitals, they reflect the high cost of hospital birth. Community births have lower rates of cesarean sections, which on its own lowers costs, but even vaginal births are lower in price in a community setting as opposed to a hospital. One study found that using a freestanding birth center could save Medicaid $11.6 million per 10,000 births, even when controlling for the fact that birth centers tend to care for women with a lower risk profile.[126]

---

[119] NAT'L ACADS. REP., *supra* note 1, at 59.

[120] *Id.* at 59–62. The specific emergency care a home birth midwife can provide varies based on state law.

[121] *Id.* at 63.

[122] *Id.* at 59–62.

[123] *Id.*

[124] NAT'L ACADS. REP., *supra* note 1, at 76. For a privately insured woman, the total payment to the hospital includes the $2,442 she is responsible on average for paying out of pocket. *Id.*

[125] *Id.*

[126] Embry Howell et al., *Potential Medicaid Cost Savings from Maternity Care Based at a Freestanding Birth Center*, 4 MEDICARE & MEDICAID RSCH. REV. E1, E1 (2014).

The primary argument against increasing access to community birth tends to be safety, even though studies have demonstrated that community birth is not unsafe[127] and that better integration of midwifery services into the overall maternal healthcare system is directly correlated to better outcomes.[128] ACOG strongly disapproves of home birth and cites statistics that demonstrate an increase in perinatal death associated with a planned community birth.[129] State regulatory bodies refer often to these statistics when deciding not to license midwives who would attend community births,[130] but they show only a tiny portion of the picture. Birth is a complex, if not complicated, event in which the mother's and baby's bodies work in tandem. Mothers who deliver in a community setting are much more likely to breastfeed their babies,[131] and breastfed babies are half as likely to die of SIDS.[132] The myopic focus on the immediate outcome of the birth fails to take into account this and other benefits associated with community birth. The emphasis on safety also ignores the practical effect of strict midwifery regulations, which do not serve to make birth safer. When women have a strong desire to avoid a hospital birth and do not have access

[127] Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 17 (2014) ("Low-risk women in this cohort experienced high rates of physiologic birth and low rates of intervention without an increase in adverse outcomes.").

[128] Saraswathi Vedam et al., *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, 13 PLOS ONE 1 (2018).

[129] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, PLANNED HOME BIRTH, COMMITTEE OPINION NO. 697 (2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/planned-home-birth [https://perma.cc/WPE3-9GAP].

[130] *Meeting Minutes*, Ga. Occupational Reg. Rev. Council 27 (Oct. 30, 2019) (statement of Bethany Sherrer, Med. Ass'n. Ga.).

[131] NATALITY, 2016-2020 EXPANDED RESULTS, CDC WONDER (Jan. 19, 2021, 2:04 PM), https://wonder.cdc.gov/controller/saved/D149/D104F454 [https://perma.cc/X7CB-T6YS] (click "I Agree" to access data). *See also* NAT'L ACADS. REP., *supra* note 1, at 207 (noting higher breastfeeding rates connected with community birth while acknowledging some element of selection bias). One possibility is that skin-to-skin contact, rooming-in, and one-on-one breastfeeding support, which are correlated with higher breastfeeding success, are offered more consistently in community birth environments, although randomized, controlled studies establishing causation are lacking.

[132] John M.D. Thompson et al., *Duration of Breastfeeding and Risk of SIDS: An Individual Participant Data Meta-analysis*, 140 PEDIATRICS 1 (2017).

to licensed care, they do not go to the hospital; they give birth unassisted[133] or with an unqualified attendant.[134]

Additionally, the focus on the fetus and infant disregards the risks to the mother. To be sure, some women (and their babies) do benefit from birthing in a hospital under the care of a physician.[135] However, for other, lower-risk women, hospitals may not be the safest place to give birth. Women who give birth in a hospital are more than four times as likely to give birth via cesarean section,[136] and surgical complications are a leading cause of maternal mortality.[137] This increase in cesarean sections is not limited to high-risk pregnancies, and physicians performed many cesarean sections in situations where they were not required.[138] In 2020, over a quarter of birthing people categorized by the CDC as low-risk delivered their baby via cesarean section.[139] Furthermore, once a woman delivers via cesarean section, there is a 90% chance that a subsequent birth will also be via

---

[133] Hannah Summers, *Expectant Mothers Turn to Freebirthing After Home Births Cancelled*, THE GUARDIAN (Apr. 5, 2020, 12:09 PM), https://www.theguardian.com/lifeandstyle/2020/apr/05/expectant-mothers-turn-to-freebirthing-after-home-births-cancelled [https://perma.cc/VUE8-P622].

[134] Vigdor, *supra* note 20.

[135] For example, some women experience *placenta previa*, a condition in which the placenta lies over or very near to the cervix, between the fetus and the birth canal. Because of the high risk of bleeding, the condition virtually always requires delivery by cesarean section before the woman goes into labor. *See* Yinka Oyelese & John C. Smulian, *Placenta Previa, Placenta Accreta, and Vasa Previa*, 107 OBSTETRICS & GYNECOLOGY 927 (2006).

[136] AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, *supra* note 130, at 2.

[137] Emily Kumler Kaplan, *Reducing Maternal Mortality*, N.Y. TIMES (Mar. 5, 2019), https://www.nytimes.com/2019/03/05/well/family/reducing-maternal-mortality.html [https://perma.cc/7X88-RYX9].

[138] This phenomenon of over-intervention is sometimes referred to as "too much too soon," in contrast with "too little too late," in which appropriate interventions are not applied. NAT'L ACADS. REP., *supra* note 1, at 162. The exact reasons physicians perform unnecessary cesarean sections are not fully known and are likely situation-specific. One study suggests provider bias, finding a correlation between race and cesarean sections, even when controlling for all other risk factors. Alison S. Bryant et al., *Quality and Equality in Obstetric Care: Racial and Ethnic Differences in Cesarean Section Delivery Rates*, 23 PAEDEATRIC & PERINATAL EPIDEMIOLOGY 454 (2009).

[139] BRADY E. HAMILTON ET AL., CDC, REPORT NO. 012, BIRTHS: PROVISIONAL DATA FOR 2020 (May 2021), https://www.cdc.gov/nchs/data/vsrr/vsrr012-508.pdf [https://perma.cc/8TP3-TBZP].

cesarean.[140] One third of hospitals and one half of obstetricians do not permit a woman to even attempt a vaginal birth after she has had a cesarean (VBAC),[141] even though women laboring in the supportive environment of their homes have successful VBACs 87% of the time.[142]

The generalized focus on safety also ignores the reality for women of color, particularly for Black and Indigenous women. In the United States, Indigenous and Black women are over two and three times as likely, respectively, as white women to die of pregnancy-related causes.[143] This disparity persists even across poverty and education levels; a college-educated Black woman is five times more likely to die of a pregnancy-related cause than her college-educated white peer.[144] A substantial portion of the racial disparity in mortality and severe morbidity can be explained by the variation in hospital quality.[145] Hospitals that serve primarily Black women have higher severe maternal morbidity rates for women across all races, even after adjusting for the patients' higher risk levels.[146]

---

[140] Kim J. Cox, *Providers' Perspectives on the Vaginal Birth After Cesarean Guidelines in Florida, United States: A Qualitative Study*, 11 BMC PREGNANCY & CHILDBIRTH 1 (2011) (noting that only 8.2% of women even attempt a vaginal birth after cesarean).

[141] Kim J. Cox et al., *Planned Home VBAC in the United States, 2004-2009: Outcomes, Maternity Care Practices, and Implications for Shared Decision Making*, 42 BIRTH 299, 300 (2015).

[142] *Id.* at 301.

[143] EMILY E. PETERSEN ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS./CDC, MORBIDITY AND MORTALITY WEEKLY REPORT VOL. 68, NO. 35, RACIAL/ETHNIC DISPARITIES IN PREGNANCY-RELATED DEATHS – UNITED STATES, 2007–2016, at 762 (2019). A pregnancy-related death is a death that occurs "during or within one year of the termination of pregnancy and was caused by a pregnancy complication, a chain of events initiated by pregnancy, or aggravation of an unrelated condition by the physiologic effects of pregnancy." *Id.* Although pregnancy-related death is rare (approximately 700 women die in the United States each year), it is estimated that for each death, 50-100 women suffer a "near-miss" severe maternal morbidity event. Stacie E. Geller et al., *A Global View of Severe Maternal Morbidity: Moving Beyond Maternal Mortality*, 15 (Supplement 1) REPRODUCTIVE HEALTH 31, 32 (2018).

[144] Petersen et al., *supra* note 143, at 763.

[145] Elizabeth A. Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387 (2018).

[146] *Id.* at 4–5. Black women are also not immune from poor outcomes at well-resourced hospitals. Serena Williams experienced a pulmonary embolism after a cesarean section and was repeatedly dismissed by hospital staff as "confused" when she tried to alert them. Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018), https://www.vogue.com/article/serena-williams-vogue-cover-interview-february-2018 [https://perma.cc/7WJX-H3K2].

Although for many Black women, especially those experiencing higher risk pregnancies, the solution to this disparity lies in improving the quality of hospital care they receive, we must also recognize that others will feel safer outside the typical medical system, especially in light of the COVID-19 pandemic's disproportionate effect on communities of color.[147] Birthing people should be allowed to make this choice themselves and have access to a qualified community birth attendant.

The most important reason, however, to increase access to community birth is also the hardest to quantify: autonomy. No birth, regardless of setting, is risk-free, and birthing people must be allowed to weigh the risks of hospital or community birth as applied to their own pregnancy. Birthing people report higher satisfaction in their birth experience when they are able to choose where and how to give birth in accordance with their values.[148] Nearly 20% of women experience some kind of mistreatment while giving birth, whether a loss of autonomy, being scolded or threatened, or having their requests for help refused.[149] These experiences differ significantly by birth location: 5.1% of people who birthed at home reported mistreatment, as opposed to 28.1% of people who birthed in a hospital.[150] Giving birth with a midwife was also associated with reduced mistreatment, regardless of birth setting.[151] As with the racial disparity in outcomes, hospitals and physicians must work to reduce this disparity in mistreatment, especially for women whose individual risk profiles or personal values make a hospital birth the best choice. However, for women who place high value on personal autonomy during birth, we must increase access to safe community birth under the care of a qualified midwife.

C. Limits on Access to Midwifery and Community Birth

Despite their education and clinical training, midwives often face barriers to their ability to practice. As the vast majority of community birth attendants are midwives, restrictions on midwives directly impact the choices available to pregnant women. This

---

[147] Alice Proujansky, *Why Black Women Are Rejecting Hospitals in Search of Better Births*, N.Y. TIMES (July 29, 2021), https://www.nytimes.com/2021/03/11/nyregion/birth-centers-new-jersey.html [https://perma.cc/MSB3-PG6K].

[148] NAT'L ACADS. REP., *supra* note 1, at 208.

[149] *Id.* at 214.

[150] *Id.*

[151] *Id.*

section describes common legislatively-imposed restrictions on midwives and how courts have upheld those restrictions.

1. Common Restrictive Regulations

The most obvious restriction is simply the refusal of a state to offer a license to a midwife. CNMs can be licensed in all fifty states, but as of May 2020 only thirty-four states and the District of Columbia provide a pathway to licensure for CPMs,[152] and only nine states provide licensure for CMs.[153] Thus, even if a midwife qualifies for the CPM or CM credential, she is not necessarily authorized by the state to practice in that jurisdiction. Some midwives seek licensure from neighboring states and must cross state lines to attend births.[154] Midwives who choose to practice illegally in their own state risk facing legal consequences and cannot bill insurance.[155] Some states also regulate midwives in a more subtle manner by making Boards of Medicine[156] or Boards of Nursing,[157] instead of Boards of Midwifery or Boards of Public Health, responsible for licensure. When midwives' competitors are granted the authority to regulate them, it is more likely that the regulators will make decisions for personal reasons rather than in the interest of the public.

Although all states license CNMs, many restrict their autonomy by requiring them to have a documented collaborative (or even supervisory) agreement with a physician in order to practice or receive a license.[158] While the laws appear to contribute to a continuity of care and ensure that a birthing mother can be efficiently transferred in case of a

---

[152] NAT'L ASS'N OF CERTIFIED PRO. MIDWIVES, *supra* note 18.

[153] AM. COLL. OF NURSE-MIDWIVES, *supra* note 79.

[154] Jo Ciavaglia, *Maternity Gap: NJ Licenses Non-Nurse Midwives, Pennsylvania Doesn't*, THE INTELLIGENCER (May 26, 2019, 9:00 AM), https://www.theintell.com/news/20190526/maternity-gap-nj-licenses-non-nurse-midwives-pennsylvania-doesnt [https://perma.cc/QBE4-CS2A].

[155] *Id.*

[156] *State by State*, MIDWIVES ALL. OF N. AM., https://mana.org/about-midwives/state-by-state [https://perma.cc/3QBL-JWTC].

[157] *Id.*

[158] Y. Tony Yang & Katy B. Kozhimannil, *Making a Case to Reduce Legal Impediments to Midwifery Practice in the United States*, 25 WOMEN'S HEALTH ISSUES 314, 315 (2015).

complication, the primary effect is simply to limit the midwife's ability to practice.[159] In Pennsylvania, for example, physicians have agreed to sign agreements with hospital and birth center midwives but categorically refuse to enter agreements with home birth midwives.[160] The unwillingness to collaborate is generally fear-based: hospital-based providers tend to believe that home birth is more dangerous than studies would suggest.[161] They perceive the community midwife to be incompetent and as having mismanaged her cases.[162] These inaccurate perceptions can be explained by simple sample selection bias: hospital-based providers generally see only the community births that required a hospital transfer.

States also place restrictions on birth centers, which are staffed primarily by midwives. Some states, like Georgia and New York, require would-be birth center operators to apply for a "Certificate of Need," which hospital operators can oppose, stating that they already fill the "need" for birthing locations.[163] Many states also require physician oversight of freestanding birth centers,[164] and midwives in those states can have the same problem finding physicians to oversee birth centers as they have finding physicians to oversee their solo practices.[165] Although midwives and birth center operators like to collaborate with physicians and hospitals, the relationships can become strained when they are obligatory or formalized with a contract.[166]

In addition to the restrictions placed directly on midwives' practices, the law also affects whether midwives can be reimbursed through insurance for their services. The National Academies Report identified that choice in birthing location is largely dictated by

---

[159] Interview with Emily McGahey, Doctor of Midwifery, Certified Nurse-Midwife (Jan. 28, 2021) [hereinafter Interview with Emily McGahey].

[160] *Id.*

[161] NAT'L ACADS. REP., *supra* note 1, at 253.

[162] *Id.* at 253–54.

[163] Letter from Lesley Rathbun, President, Am. Ass'n of Birth Centers, to Donald S. Clark, Sec'y, Fed. Trade Comm'n (Apr. 30, 2014), https://www.ftc.gov/system/files/documents/public_comments/2014/04/00171-90023.pdf [https://perma.cc/PZ2R-Z9HU] [hereinafter Letter from Lesley Rathbun].

[164] *E.g.*, 28 Pa. Code § 501.72.

[165] Letter from Lesley Rathbun, *supra* note 163.

[166] Interview with Emily McGahey, *supra* note 159.

a woman's ability to pay.[167] Even when midwives are authorized to practice in a community setting, the associated out-of-pocket cost can be prohibitively expensive for many women. In 2017, 32.2% of the nation's birth center births and 67.9% of home births were not covered by insurance,[168] which means that only women who could afford a midwife's fees were able to exercise meaningful choice in their birthing location. Medicaid, which the most vulnerable women rely on for maternity care, covered 43.4% of hospital births but only 17.9% of birth center births and 8.6% of home births,[169] and most states do not offer Medicaid reimbursement to the midwives who would attend a home birth.[170] The Affordable Care Act requires that Medicaid reimburse services in freestanding birth centers,[171] but many states and Medicaid-managed care organizations have not implemented this statutory requirement.[172]

2. Why Barriers Remain

Midwives and their clients have attempted to argue in court against restrictive regulations but have had little success. According to the courts, legislatures are not infringing on the rights of birthing women by making community birth practically impossible, and they are not infringing on the rights of midwives by giving physicians authority over the midwives' practices.

Roe v. Wade,[173] heralded as a landmark case for women's right to bodily autonomy, has been used, ironically, to deny women the right to choose their own birthing environment. A small group of community midwives in Santa Cruz, California founded

---

[167] NAT'L ACADS. REP., *supra* note 1, at 75.

[168] MacDorman & LeClercq, *supra* note 71, at 284.

[169] *Id.* at 285.

[170] Yang & Kozhimannil, *supra* note 158, at 315.

[171] Social Security Act §1902(a)(10)(A), 42 USC § 1396a(10)(A); Social Security Act §1905(a)(28), 42 U.S.C. § 1396d(28).

[172] Letter from Kate Bauer, Exec. Dir., Am. Ass'n of Birth Ctrs., Jesse S. Bushman, Dir., Advoc. & Gov't Affs., Am. Coll. of Nurse-Midwives, & Mary Lawlor, Exec. Dir., Nat'l Ass'n of Certified Pro. Midwives, to Victoria Wachino, Acting Deputy Adm'r & Dir., Ctr. for Medicaid and CHIP Servs. https://www.midwife.org/acnm/files/ccLibraryFiles/Filename/000000005105/AABC-ACNM-NACPM-LettertoCMSonBirthCenterRegulation.pdf [https:/perma.cc/C3YM-4HGU].

[173] 410 U.S. 113 (1973).

the Birth Center in 1971 with two goals in mind: provide prenatal care for women who disagree with the medical model of maternity care and assist these women in giving birth at home.[174] Although California law required midwives to be licensed, the law at the time had also prohibited the issuance of new midwifery certificates since 1949.[175] The Birth Center midwives were arrested in a sting operation in March 1974[176] and charged with violating Section 2141 of the Business and Professions Code, which "prohibit[ed] the unlicensed practice of the healing arts."[177] Among other claims, the midwives argued that Section 2141, if meant to prohibit attending and assisting a pregnant woman in childbirth, unconstitutionally violated the mother's right of privacy.[178]

The court did not agree, holding instead that

> the right of privacy has never been interpreted so broadly as to protect a woman's choice of the manner and circumstances in which her baby is born. Indeed, *Roe*, supra, appears specifically to exclude the right to make such choices from the constitutional privacy right. . . . For the same policy reasons for which the Legislature may prohibit the abortion of unborn children who have reached the point of viability, it may require that those who assist in childbirth have valid licenses.[179]

The *Bowland* decision has been cited by jurisdictions as diverse as Massachusetts and Colorado to deny women their choice of childbirth attendant.[180]

Midwives have also tried unsuccessfully to argue that placing physicians in control of how and whether they practice is an unconstitutional violation of their right to practice their chosen profession. Kansas law prohibits advanced practice registered nurses, which

---

[174] KLINE, *supra* note 26, at 106–07.

[175] Bowland v. Mun. Ct., 556 P.2d 1081, 1086 (Cal. 1976).

[176] KLINE, *supra* note 26, at 96.

[177] *Bowland*, 556 P.2d at 1082.

[178] *Id.* at 1088–89.

[179] *Id.* at 1080.

[180] Michael A. Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 BRANDEIS J. FAM. L. 609, 616–17 (1997).

includes CNMs, from making independent decisions regarding the care of their patients without a collaborative practice agreement (CPA) with a physician.[181] Two Kansas midwives sued the state's Board of Nursing after their collaborating physician decided to terminate their CPA, and they were unable to find another physician who would enter into a CPA with them.[182] The midwives alleged that, in prohibiting practices without CPAs and allowing physicians to unilaterally decide whether to collaborate with midwives, the Board had impermissibly deprived them of their liberty and property rights to practice their chosen profession, in violation of the United States Constitution's 14th Amendment.[183] They argued that the termination of their CPA should have been afforded the same procedural protections as would have been afforded for the revocation of their licenses.[184] The Kansas District Court dismissed the complaint on a 12(b)(6) motion for failure to state a claim.[185] The court held that because Kansas's CPA limitations on a nurse's license were in furtherance of a legitimate state interest, there was no equal protection violation.[186]

Because courts have not found that restrictions on midwifery violate fundamental rights, midwives and their clients must seek recourse in the legislature. This has been a slow process because, as explained in Part I of this Note, midwives have been subject to sexist, racist, and anti-immigrant campaigns by physicians seeking to consolidate power and corner the market. This historic de-legitimization of midwifery means that midwives must constantly prove themselves, a burden that physicians do not have. For example, in Nebraska, any change to a health profession's scope of practice or any addition of a new credential must pass through the state's Credentialing Review Program, also known as a 407 Review.[187] This requires midwives to prove to the Board of Health (which has no position reserved for a midwife[188]) that public health or welfare is endangered and cannot

[181] Kan. Admin. Regs. § 60-11-101.

[182] Gorenc v. Klaassen, 421 F.Supp. 3d 1131, 1139–40 (D. Kan. 2019).

[183] *Id.* at 1141.

[184] *Id.*

[185] *Id.* at 1157.

[186] *Id.* at 1160.

[187] *Credentialing Review (407) Program*, NEB. DEP'T OF HEALTH & HUM. SERVS., https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx [https://perma.cc/47NS-TRUU].

[188] *Board of Health*, NEB. DEP'T. OF HEALTH AND HUM. SERVS., https://dhhs.ne.gov/licensure/pages/board-of-health.aspx [https://perma.cc/754G-HQJ2].

be remedied by means other than expanding midwifery practices.[189] Midwives must prove their superiority to physicians; it is not enough that they be licensed in order to provide a choice for expecting parents. This Note will further show in Part III how legislatures defer to the authority of physicians.

D. Improved Midwifery Legislation

Although historically, midwifery regulations were used with the intent of severely restricting midwifery,[190] such legislation can be structured in a way that enhances public safety and does not inappropriately limit a midwife's ability to practice. Women who wish to engage the services of midwives should have a mechanism for ensuring that their midwife has been trained and educated, but the state should allow for all categories of midwives to practice within the scope of that training and education, without imposing undue restrictions. Seven organizations,[191] working together as U.S. MERA, drafted a set of principles for model midwifery legislation and regulation.[192] U.S. MERA recommends that states establish a midwifery-specific board or other regulatory authority that is empowered to effectively and autonomously regulate midwives (including by receiving and resolving complaints against midwives) and that the regulations rely on standards and certifications developed by existing midwifery agencies, such as NARM and ACMB.[193]

New Mexico and Washington are two states whose regulatory structures can serve as examples for others.[194] These two states achieved the top midwifery integration scores in the nation and have superb maternal and infant health statistics.[195] Both states license their

---

[189] NEB. REV. STAT. ANN. § 71-6221 (LexisNexis 2021).

[190] *See supra* Section I.C.

[191] Accreditation Commission for Midwifery Education, American College of Nurse-Midwives, American Midwifery Certification Board, Midwives Alliance of North America, Midwifery Education Accreditation Council, National Association of Certified Professional Midwives, and North American Registry of Midwives.

[192] U.S. MIDWIFERY EDUC., REGUL., & ASS'N, PRINCIPLES FOR MODEL U.S. MIDWIFERY LEGISLATION & REGULATION (2015), http://www.usmera.org/wp-content/uploads/2015/11/US-MERALegislativeStatement2015.pdf [https://perma.cc/4MED-75UC].

[193] *Id.* at 6–8.

[194] Both states still have room for improvement; for example, neither state licenses CMs. *See* AM. COLL. OF NURSE-MIDWIVES, *supra* note 79.

[195] Vedam et al., *supra* note 129, at 8.

midwives through the Public Health Divisions of their respective Departments of Health rather than through Boards of Medicine or Boards of Nursing.[196] Nationwide, 32% of birth center births and 68% of home births were paid for out-of-pocket by the families.[197] In New Mexico, families paid out-of-pocket for 5% of birth center births and 35% of home births.[198] The Washington figures are even more impressive: less than 5% of birth center births and 18% of home births were self-paid.[199] These figures indicate that birth setting is a true matter of choice in these locations, rather than something dictated to women by their ability to pay. Both states also have higher than average rates of community birth covered by Medicaid, so the choice is not limited to women with private insurance.[200]

CNMs in New Mexico are autonomous practitioners who are expressly authorized to practice in all settings, from birth centers and homes to hospitals and clinics.[201] The state law defers to the American College of Nurse-Midwives (ACNM) to define the standards of practice for CNMs, and rather than mandate a contractual relationship with a physician, the law provides only that she practice "within a health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client," trusting the midwife to use her professional judgment.[202] CNMs have full prescriptive authority for all but the most dangerous drugs.[203] New Mexico also provides payment assistance for liability insurance to CNMs who serve primarily indigent clients.[204]

---

[196] MIDWIVES ALL. OF N. AM., *supra* note 156.

[197] MacDorman & LeClercq, *supra* note 71, at 283.

[198] *Id.* at 296.

[199] *Id.* at 297.

[200] *Id.* at 296–97.

[201] N.M. CODE R. § 16.11.2.10.A (LexisNexis 2021).

[202] *Id.*

[203] § 16.11.2.10.B.

[204] § 7.30.9.

New Mexico licenses CPM-credentialed midwives and refers to them as Licensed Midwives.[205] The state publishes extensive practice guidelines[206] for these midwives and requires them to pass a written examination on the guidelines in order to obtain their license.[207] CPMs in New Mexico are also autonomous practitioners. They are required to collaborate with physicians, but the regulatory structure contributes to an atmosphere of collaboration rather than subordination.[208] The midwife must refer all clients to a physician at least once during her pregnancy,[209] which ensures that a physician is able to confirm that the woman does in fact have a low-risk pregnancy. The midwife is also required to develop a means for consultation and transfer to a physician or hospital if necessary.[210] The law limits the liability of the physician, so that he or she is not held liable for any negligence on the part of the midwife purely as a result of that consultative relationship,[211] which encourages physicians to work with midwives rather than remain at arm's length. CPMs are authorized to procure and administer medications that are commonly used during pregnancy and birth, even including standard vaccines for newborns.[212]

Washington, like New Mexico, licenses CPMs as Licensed Midwives.[213] It similarly encourages collaboration between physicians and midwives without requiring a formal agreement. State law requires a midwife to consult with a physician whenever she identifies a significant deviation from normal pregnancy,[214] and she must submit a written plan for

---

[205] § 16.11.3.12.

[206] N.M. MIDWIVES ASS'N, PRACTICE GUIDELINES (2019 ed.), https://www.nmhealth.org/publication/view/guide/1725/ [https://perma.cc/9WGT-7HUP].

[207] § 16.11.3.8.

[208] *See* § 16.11.3.12.

[209] *Id.*

[210] *Id.*

[211] *Id.*

[212] N.M. MIDWIVES ASS'N, *supra* note 206, at 15–18.

[213] WASH. REV. CODE ANN. § 18.50.040 (LexisNexis 2021). Note that Washington does not require a midwife to possess the CPM credential to obtain licensure, and even CPMs must meet additional state licensing criteria. WASH. ADMIN. CODE § 246-834-066 (2021).

[214] § 18.50.010.

consultation and emergency transfer with her license application.[215] Washington's CNMs are regulated as advanced registered nurse practitioners[216] and are given broad latitude to function as primary care providers who collaborate with other healthcare professionals.[217] Washington law requires all health plans to reimburse all healthcare provider categories, which include CNMs and other licensed midwives.[218] Finally, Washington law requires that liability insurance providers be part of a joint underwriting association to provide malpractice insurance for both categories of midwives.[219]

III. A Varied Landscape: The States' Unique Histories and Regulation of Midwives

Although the United States broadly followed the path described in Part II, each state has its own history of regulating midwives, and each state's current regulatory scheme is unique. Part III presents the legislative history of four states' current midwifery regulations, recent developments or attempts at change, and the current status of community birth in each state. The states were chosen for their diversity of regulatory structures, although they do share one notable trait: none offer a pathway to licensure for CPMs. Section III.A looks at Nebraska, which remains the only state where no licensed midwives are permitted to attend home births. Section III.B discusses Georgia, a state with one of the highest maternal mortality rates, and a state which stopped issuing licenses to CPMs in 2015. Georgia is an example of how non-nurse midwives can become disenfranchised when Boards of Nursing are responsible for regulating midwifery. New York, discussed in Section III.C, serves as a further example of how birthing women lose options when nurse-midwives gain power at the expense of lay midwives. Pennsylvania, discussed in Section III.D, is the only state that regulates its CNMs through both the Board of Nursing and the Board of Medicine. Pennsylvania tacitly allows home-birth midwives but has no formal procedures for granting them licenses, which puts their clients at risk.

---

[215] § 18.50.108.

[216] WASH. ADMIN. CODE §§ 246-840-020, 246-840-302 (2021).

[217] § 246-840-300.

[218] WASH. REV. CODE ANN. § 48.43.045 (LexisNexis 2021).

[219] § 48.87.010.

A. Nebraska

Nebraska, which has created one of the most restrictive environments for midwives, did not officially regulate them until the state passed LB 761 in 1984. Before that bill's passage, Nebraska was one of only two states—the other being North Dakota—with no provision for the practice of nurse-midwifery.[220] The law was also silent on community midwifery, but the Medical Practice Act prohibited the practice of obstetrics by anyone other than a physician.[221] The Nebraska Attorney General has interpreted the Medical Practice Act to prohibit even the father from serving as the attendant in a planned home birth.[222]

In the summer of 1982,[223] Karen Amen-Jensen and Ann Seacrest founded Nebraskans for Certified Nurse Midwives.[224] Ms. Seacrest, a new arrival to Nebraska,[225] was frustrated that she could not find a midwife to attend her birth, so she and Ms. Amen-Jensen, a third-generation Nebraskan, organized with others to advocate for the legalization of CNMs.[226] Membership in the group ballooned to 700 by January 1984.[227] The two women drafted legislation[228] and found support for their initiative in Senator Shirley Marsh, who served on the National Advisory Board to the American College of Obstetricians and

---

[220] 88 NEB. LEG. REC. LB761 (daily ed. Mar. 7, 1984) (statement of Sen. Shirley Marsh), https://www.nebraskalegislature.gov/FloorDocs/88/PDF/Transcripts/FloorDebate/Floor09097.pdf [https://perma.cc/23NF-8T8J].

[221] NEB. REV. STAT. § 71-1103 (1981).

[222] Neb. Att'y Gen. Op. No 206 (Mar. 28, 1984).

[223] *L.B. 761: Hearing Before the Comm. On Pub. Health & Welfare*, 1984 Leg., 88th Sess. 27 (Neb. 1984) (statement of Deb Evans).

[224] *Hearing on L.B. 837 Before the Comm. On Health & Human Servs.*, 1993 Leg., 93d Sess. 21 (Neb. 1993) (statement of Karen Amen-Jensen).

[225] Cindy Lange-Kubick, *Ann Seacrest and MilkWorks — Her Baby Ready to Wean*, LINCOLN JOURNAL STAR (Sept. 4, 2020), https://journalstar.com/news/local/cindy-lange-kubick-ann-seacrest-and-milkworks-her-baby-ready-to-wean/article_b908972f-67cc-5178-b9c6-430bdb7b4a4d.html [https://perma.cc/3A4Y-8NL6].

[226] *Hearing on L.B. 837 Before the Comm. On Health & Human Servs.*, *supra* note 224.

[227] *L.B. 761: Hearing Before the Comm. On Pub. Health & Welfare*, *supra* note 223.

[228] *Id.*

Gynecologists.[229] The first draft of the bill, which authorized midwives to attend to normal childbirth and required them to practice under the supervision of a physician, did not restrict the physical practice location of the midwives and would have permitted them to attend home deliveries.[230]

Proponents of the law recognized that some legislators might fear an increase in home births if midwifery were legalized and attempted to assuage those fears, explaining that physicians were unlikely to allow the midwives they supervised to practice outside hospitals.[231] Physicians and representatives of the Nebraska Medical Association nonetheless registered their formal opposition to the bill out of concern that unsupervised midwives would attend home births.[232] The legislators appeared surprised at the response from the medical community, given that public hearings and interim studies had been conducted without any such opposition raised.[233] As Senator Marsh closed the hearing, she voiced frustration that none of the physicians, who had been anticipating this bill, had contacted her earlier to discuss their concerns.[234] The committee hearing closed and did not advance the bill for two weeks while the midwifery advocates and medical community worked out a consensus.[235]

---

[229] *Id.* at 23 (statement of Sen. Shirley Marsh, bill sponsor).

[230] *See* Comm. On Pub. Health and Welfare, Committee Statement on LB 761 (Jan. 31, 1984), https://www.nebraskalegislature.gov/FloorDocs/88/PDF/CS/LB761.pdf [https://perma.cc/C993-RX6A] (amending the proposed bill to prohibit home deliveries by CNMs).

[231] L.B. 761: Hearing Before the Comm. On Pub. Health & Welfare, *supra* note 223, at 32 (statement of Ann Raschke) ("Perhaps the biggest area of misconception that we have to deal with is the link between nurse midwives and home birth. If we legalize nurse midwives, will the number of home births increase? It is true that nationwide a small number of CNMs do attend home births, but only when their collaborating physician agrees with this site for birth. Nebraska physicians currently have a very strong policy in not supporting the concept of home birth. I ask you, what in LB 761 would lead anyone to believe that our physicians will change their minds? The process of a formal practice agreement outlining the site will leave this decision where it belongs, with the health care professionals.").

[232] *Id.* at 54 (statement of Robert Shapiro, Neb. Med. Ass'n).

[233] *Id.* at 57 (statement of Sen. George Fenger, Comm. Chairman).

[234] *Id.* at 65 (statement of Sen. Shirley Marsh, bill sponsor) ("I do know that there have been professionals individually who have been willing to speak and have their input. I do know that I talked in December with a very well-known Ob-Gyn physician in the city of Lincoln, and I do know that many persons were aware this bill was to be heard in public hearing today. Not one of the physicians contacted me and said, 'I'd like to talk about this.' Not one.").

[235] *See id.* at 66.

As Ms. Amen-Jensen testified in a later legislative session, during those negotiations "[w]e did not discuss the pros and cons of the home birth. The safety of home birth was never an issue," but the midwifery advocates were willing to concede home births in order to achieve baseline legal recognition for CNMs.[236] By the time the bill was presented for debate on the legislative floor, it prohibited all CNMs from attending home births, even if the supervising physician would have otherwise authorized it.[237]

Nebraska's Certified Nurse Midwifery Practice Act has remained largely unchanged since it first became law in 1984. CNMs, the only midwives recognized in Nebraska, are required to maintain a written practice agreement with a physician,[238] which gives the physician substantial control over the midwife's practice, as the physician is free to choose whether to enter into an agreement with a midwife. The agreement "[d]efines or describes the medical functions to be performed by the certified nurse midwife . . . as agreed to by the nurse midwife and the collaborating licensed practitioner,"[239] meaning that, because of the difference in contract power between the physician and midwife, the physician may effectively dictate the terms of the midwife's practice to her. Midwives are the only practitioners who are required to enter into an agreement with a physician in order to practice; all other advanced practice registered nurses may practice autonomously.[240] In 2019, 0.15% of Nebraska's births took place in a freestanding birth center and 0.37% took place at home, compared to nationwide rates of 0.53% and 1.02%, respectively.[241]

Nothing in the Certified Midwifery Practice Act explicitly prohibits direct entry midwives from practicing, but they may face prosecution under the Medical Practitioners Act. In September 1992, Karen Gourley, an Omaha-based lay midwife, attended a birth in

---

[236] *Hearing on L.B. 837 Before the Comm. On Health & Human Servs.*, *supra* note 224, at 22 (statement of Karen Amen-Jensen).

[237] 88 NEB. LEG. REC. LB761, *supra* note 220.

[238] NEB. REV. STAT. § 38-609 (2021).

[239] *Id.*

[240] 172 NEB. ADMIN. CODE § 172-98-003 (2020).

[241] *Natality Public-Use Data 2016–2019*, CDC WONDER (Jan. 28, 2021, 2:08 PM), https://wonder.cdc.gov/controller/saved/D66/D108F166 [https://perma.cc/9R2Q-R8KG] (click "I Agree" to access data).

Lincoln at the home of Rhonda and David Shoenmaker.[242] The baby was breech and did not survive.[243] Gourley did not face any charges in connection with the baby's death, but she was charged with a Class IV felony under the Certified Midwifery Practice Act for practicing midwifery without a license.[244] The state argued that Gourley, by serving as a childbirth attendant in a non-emergency situation, had performed the functions of a certified nurse-midwife without a valid certification.[245] (The statute expressly permits even non-certified individuals from attending childbirth in an emergency.)[246] The county judge, however, quickly dismissed the case in April 1993, stating, "It is this court's opinion that the language of the statute only prohibits a person from holding themselves out as a certified nurse midwife when they were not so certified."[247] The judge's ruling meant that, with respect to the Certified Midwifery Practice Act, lay midwifery was not illegal, so long as the midwives did not present themselves as nurses.

In response to the court's ruling, State Senator Don Wesely, chair of the Health and Human Services Committee, pledged to close the loophole, claiming that the legislature had never intended to allow lay midwifery.[248] Within a week, he introduced an amendment to LB 837, a bill that was originally drafted to address unprofessional conduct by medical practitioners, to clarify that non-nurse midwives were not authorized to practice.[249] The bill as amended did not become law, but not because the legislature wanted to permit lay midwifery. Instead, lawmakers realized that it was unnecessary because lay midwifery was

---

[242] Margaret Reist, *Charge Dropped Against Midwife in Case of Breech Baby Who Died*, LINCOLN JOURNAL STAR, Apr. 27, 1993, at 5.

[243] *Id.*

[244] Validity of Op. Att'y Gen. No. 206 (Mar. 28, 1984) in View of State v. Gourley; Practice of Lay Midwifery as the Unauthorized Practice of Medicine and Surgery, Neb. Att'y Gen. Op. No. 93039 at 2 (May 17, 1993).

[245] *Id.*

[246] NEB. REV. STAT. § 38-612 (2020).

[247] Marc Krasnowsky, *Judge Rules Law Does Not Prohibit Lay Midwifery*, LINCOLN JOURNAL STAR, Apr. 28, 1993, at 16.

[248] *Id.*

[249] *Hearing on L.B. 837 Before the Comm. On Health & Human Servs.*, *supra* note 224, at 1 (statement of Sen. Don Wesely).

already illegal under the state's Medical Practice Act,[250] a position endorsed by the State Attorney General.[251]

Nebraska's CNMs remain prohibited from attending home births, despite numerous legislative proposals from midwives and consumer organizations to remove this prohibition. Legislative Bill 1091, introduced in 1998, would have allowed CNMs to attend home births.[252] The Nebraska Medical Association suggested in the bill's committee hearing that giving birth at home is something that occurs in "Third World" countries, and that babies are put at risk by parents who carelessly choose home birth.[253] As a result of the bill even appearing before the legislature, physicians retaliated against midwives by refusing to enter into practice agreements with them, pressuring the Nebraska chapter of ACNM into testifying in opposition to the bill.[254] Today, Nebraska is the most restrictive state in terms of community birth options, given its refusal to allow any trained practitioner other than a physician to attend a home birth.

B. Georgia

Despite the shift toward hospital-based births and the accompanying replacement of community midwives with CNMs, CPMs and other home-birth midwives continued to practice openly in Georgia, and were officially regulated by the Department of Public Health from 1955 until 2015. In the mid-20th century, Georgia's midwives were actively endorsed by the government; in 1952, the Department of Health created a training film for

[250] *Id.* at 9.

[251] Validity of Op. Att'y Gen. No. 206 (Mar. 28, 1984) in View of State v. Gourley; Practice of Lay Midwifery as the Unauthorized Practice of Surgery, *supra* note 244. However, the State Attorney General also noted that the Medical Practice Act's failure to specifically mention or define midwifery could cause it to be challenged as unconstitutionally vague, were it to be used to actually prosecute a midwife.

[252] L.B. 1091, 95th Leg., 2d Sess. (Neb. 1998).

[253] *Hearing on L.B. 1091 Before the Comm. On Health & Human Servs.*, 1998 Leg., 95th Sess. 44-45 (Neb. 1998) (statement of David Buntain, Neb. Med. Ass'n).

[254] *Id.* at 40–41 (statement of Marilyn Lowe).

midwives featuring grand midwife[255] Mary Coley.[256] However, in 1979, the Department of Public Health adopted an internal policy to recognize only CNMs.[257] Although the written regulations provided otherwise, any midwife without a nursing degree who appeared before the department was not granted a license.[258]

In 2015, the Department of Public Health issued a new rule: "No person shall practice midwifery, or hold himself or herself out to the public as a midwife, unless that person has a current certification from the Georgia Board of Nursing to practice as a Certified Nurse-Midwife."[259] Although the notice of proposed rulemaking claimed that the Department had permitted only CNMs to practice midwifery for over twenty years, and the Department did not intend this rule to create any substantive changes,[260] it was a surprise to the community-birth midwives who had been practicing in Georgia for decades.[261] Earlier regulations defined midwife as "a registered professional nurse who has completed educational preparation as a nurse-midwife and who is certified by the certifying agent of the American College of Nurse-Midwives," but those regulations then went on to limit only the practice of "nurse-midwifery" rather than the more general "midwifery."[262]

In 2019, bills were proposed in the Georgia House and Senate in response to the 2015 rule change, but neither became law before the end of session. Georgia's Occupational

---

[255] Grand midwife is the modern respectful term for Southern Black lay midwives who had previously been referred to as "granny" midwives. *See* Keisha Goode & Barbara Katz Rothman, *African American Midwifery, a History and a Lament*, 76 AM. J. ECON. & SOCIO. 65, 72 (2017).

[256] ALL MY BABIES… A MIDWIFE'S OWN STORY (Center for Mass Communication of Columbia University Press 1953), https://www.loc.gov/item/2017604960/?# [https://perma.cc/VK32-VMSC].

[257] Ga. Occupational Regulation Review Council Meeting Minutes, *supra* note 131, at 26 (statement of Megan Andrews, Dept. of Public Health).

[258] *Id.*

[259] Ga. Dep't of Pub. Health, Notice of Proposed Rulemaking Revision to Regulation 511-5-1 (Sept. 11, 2015).

[260] *Id.*

[261] Kelsey Podo, *The Law Changed, Midwives Didn't Know and Now This Woman is Speaking Out*, GAINESVILLE TIMES (Jan. 11, 2020), https://www.gainesvilletimes.com/news/health-care/law-changed-midwives-didnt-know-and-now-woman-speaking-out/ [https://perma.cc/EL4S-WXUQ].

[262] GA. COMP. R. & REGS. 511-5-1-.01 (2013).

Regulation Review Council voted heavily against recommending HB 717,[263] which would have created an Advisory Board of Licensed Midwives and a pathway to licensure for CPMs.[264] A lack of accessible Georgia committee transcripts makes compiling an official history difficult, but some insight can be gained from the Council's review of the proposed legislation. CPMs testified before the Council that their lack of licensure meant they were unable to order the routine battery of lab tests that women undergo during their pregnancy.[265] The Council responded by painting the CPMs into a corner: if a midwife had a way to obtain lab-work for her clients, by establishing an informal relationship with a licensed provider who could order labs for her, she had shown that her own lack of licensure was not a real problem; but if the midwife had no way of obtaining lab-work for her clients, she had demonstrated herself to be a negligent provider.[266] In the Council meeting minutes, questions regarding the midwives' qualifications went on for twenty pages.[267] Representatives from the medical community spoke for a combined total of six pages, receiving only one substantive question, which was swiftly deflected.[268] The Council meeting was eerily reminiscent of the debate surrounding the "midwife problem" from a century ago. The medical community acknowledged Georgia's high maternal mortality rate, yet accepted none of the responsibility for that rate and instead used it to justify denying CPMs a path to licensure.[269]

---

[263] Ga. Occupational Reg. Rev. Council, H.B. 717 Licensing Certified Professional Midwives, LC 33 7832: A Review of the Proposed Legislation, at 15 (2019).

[264] Georgia Licensed Midwife Act, H.B. 717 § 43-24B-3 (2019).

[265] Ga. Occupational Regulation Review Council Meeting Minutes, *supra* note 131, at 16 (statement of Paige White, CPM).

[266] *Id.* at 20 (statement of Jessica Simmons, Dept. of Revenue).

[267] *Id.* at 6–25.

[268] *Id.* at 26–29, 32–35. Gabriel Sterling of the Office of the Secretary of State noted the lack of rural hospitals and asked, "What is your organization's position as to what is the way to provide more access in those areas that are underserved right now?" Bethany Sherrer of the Medical Association of Georgia responded that rural areas make home birth even more dangerous, and "the population just doesn't always support someone down there," but "we have maternal and fetal medicine physicians that are sort of working with rural areas, and they're doing a lot of this through telemedicine." *Id.* at 29.

[269] *Id.* at 33 (statement of Al Scott, Ga. OBGYN Soc. Pres.).

In 2017, 0.64% of Georgia births took place at home, and another 0.24% took place in a birth center.[270] Both figures were below the national average, although Georgia's community birth rate had been slowly and steadily trending upward since at least the mid-2000s. However, it remains to be seen how the Department of Public Health's rule restricting licensure to CNMs will affect community birth. Many CPMs did not realize that they had been practicing illegally until 2019.[271] Also in late 2019, one CPM began receiving cease-and-desist notices from the Board of Nursing requiring her to stop referring to herself as a midwife.[272] After the midwife sued the Board, it agreed to allow her to use her title so long as she included a disclaimer that she was not currently practicing in Georgia.[273]

Although Georgia is not as restrictive as Nebraska, the Georgia structure exemplifies the harm that comes from allowing competitors to regulate each other. Because Georgia has a Board of Nursing rather than a Board of Midwifery, CPMs have no official way to advocate for themselves professionally. Midwives are not only in competition with physicians but with other categories of midwives. States must create regulatory structures that ensure all midwives' interests are adequately represented.

C. New York

New York's current midwifery statute was passed as the Professional Midwifery Practice Act (PMPA) in 1992. The PMPA regulates midwives under the Department of Education, which established a Board of Midwifery to promulgate rules.[274] Accounts differ between CNMs and home-birth lay midwives, but it appears that lay midwives were excluded from the law in an effort to secure its passage.[275] Lay midwives had been under the impression that they would have seats on New York's new Board of Midwifery, but

---

[270] MacDorman & DeClercq, *supra* note 71, at 281.

[271] Podo, *supra* note 261.

[272] Jim Manley & Caleb Trotter, *Call the Midwife – But Not If You Live in Georgia*, THE HILL (Dec. 16, 2019, 7:00 AM), https://thehill.com/opinion/healthcare/474216-call-the-midwife-but-not-if-you-live-in-georgia [https://perma.cc/7XD2-M5HF].

[273] Consent Order and Final Judgment, Pulley v. Thompson, No. 1:19-cv-05574-AT (D. Ga., 2020).

[274] N.Y. EDUC. LAW § 6954 (McKinney 1998).

[275] Jennifer Block, *The Criminalization of the American Midwife*, LONGREADS (Mar. 10, 2020), https://longreads.com/2020/03/10/criminalization-of-the-american-midwife/ [https://perma.cc/P9ME-SKYA].

ultimately that was not the case; instead, the board issued regulations that all but assured only CNMs would be granted licenses in the state.[276] In early 1995, the Board of Midwifery invited lay midwives to apply for licenses, but all thirteen applicants received letters of denial on December 8, 1995.[277] Within a month of receiving their letters, ten midwives received cease-and-desist letters; some were also arrested and charged with the felony of practicing midwifery without a license.[278]

One of those midwives, Julia Lange-Kessler, and three of her former clients challenged the PMPA in federal court as a violation of substantive due process and the right to privacy.[279] The district court granted summary judgment in favor of the government, and the circuit court affirmed.[280] Lange-Kessler argued that the law's requirement for a written practice agreement in conjunction with the requirement for a midwife to possess a "nursing degree or equivalent" made home-birth practice effectively impossible, thus violating her right to practice her chosen profession of home-birth midwifery.[281] She presented testimony from multiple CNMs who were unable to attend home births because physicians would not formally collaborate with them due to pressure from their peers or fears of increased insurance premiums.[282] The clients then argued that the effective impossibility of securing the services of a home-birth midwife violated their right to privacy, which encompassed the right to give birth in the setting of their choice.[283] In response, the state submitted a single affidavit from an obstetrician who listed possible complications during

[276] N.Y. COMP. CODES R. & REGS. TIT. 8 § 79-5.2 (2021). The CM credential was not established until 1994. CMs can practice because they have a master's degree in midwifery and take the same licensing exam as CNMs.

[277] Maureen May & Robbie Davis-Floyd, *Idealism and Pragmatism in the Creation of the Certified Midwife: The Development of Midwifery in New York and the New York Midwifery Practice Act of 1992*, *in* MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 81, 136 (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006).

[278] *Id.* at 137.

[279] Lange-Kessler v. Dep't of Educ., 109 F.3d 137 (2d Cir. 1997).

[280] *Id.* at 139.

[281] *Id.*

[282] Brief for Appellant at 2-3, Lange-Kessler v. Dep't of Educ., 109 F.3d 137 (2d Cir. 1997).

[283] *Id.* at 24.

labor and asserted that lay midwives could not be qualified to respond to them.[284] Unsurprisingly, both courts held that the PMPA was rationally related to the state's legitimate interest in protecting the health and welfare of mothers and infants, given that a legislature could have reasonably found that only nurse-midwives with a formal relationship with a physician are competent to attend births.[285] The circuit court went on to find that Lange-Kessler's clients had not shown that they had tried to engage the home-birth services of a physician or CNM, so the PMPA had not restricted their alleged right to a home birth.[286]

In 2010, New York passed the Midwifery Modernization Act, which removed the requirement for licensed midwives to maintain a written practice agreement with a physician and replaced it with the requirement for collaboration.[287] Although this new law has given New York's licensed midwives the ability to practice autonomously, New York still has significant barriers to birthing choice because it does not license CPMs, who, unlike CNMs and CMs, cannot take the American Midwifery Certification Board's exam,[288] and was slow to implement updated regulations for midwife-led birthing centers.[289]

New York continues to actively enforce its licensing laws and recently prosecuted Elizabeth Catlin, a CPM who had attended births in a Mennonite community.[290] Ms. Catlin was first arrested after she accompanied a birthing woman to the hospital.[291] The baby later died of sepsis, and someone at the hospital reported her to the authorities,[292] although other

---

[284] *Lange-Kessler*, 109 F.3d at 140.

[285] *Id.* at 141.

[286] *Id.* at 142.

[287] N.Y. EDUC. LAW § 6951 (McKinney 2010).

[288] *Certification Examination*, AM. MIDWIFERY CERTIFICATION BD. (2018), https://www.amcbmidwife.org/amcb-certification [https://perma.cc/8GD9-VTR6].

[289] Julie Satow, *Why New York Lags So Far Behind on Natural Childbirth*, N.Y. TIMES (Nov. 13, 2018), https://www.nytimes.com/2018/11/30/nyregion/mount-sinai-west-birthing-center-natural-childbirth.html [https://perma.cc/ADE8-W3XJ].

[290] Pager, *supra* note 19.

[291] *Id.*

[292] *Id.*

midwives who have reviewed the case agree that Ms. Catlin did not cause the baby's death.[293] She was indicted in December 2019 on charges of criminally negligent homicide, unauthorized practice of the profession of midwifery, and ninety-three other counts related to "fraudulently" practicing.[294] Ms. Catlin's Mennonite clients, who prefer to avoid hospital births and live in rural areas without access to physicians or licensed midwives, defied social norms by packing the courtrooms and speaking out against her charges.[295] On September 14, 2021, Ms. Catlin pleaded guilty to the single count of unauthorized practice of a profession in exchange for the dismissal of all other charges.[296] She was sentenced in December 2021 to 5 years' probation and 250 hours of community service.[297]

Of the four states discussed in this Note in detail, New York arguably has the statutory structure most likely to achieve the ideal of making community birth and midwifery care widely accessible. However, it also serves as a cautionary tale of how legislation's intended positive effects can be hampered when the regulations necessary to fully implement the statutes are not prioritized.

D. Pennsylvania

Pennsylvania first regulated specific conduct by midwives in 1895. The law at that time, intended to prevent blindness in infants, required midwives to report infants with inflamed eyes to their town's health officer.[298] Although the state did not license midwives or formally regulate the profession, the health officer must have had methods of

---

[293] Block, *supra* note 275.

[294] Gwen Chamberlain, *Upstate NY Woman Charged with Unauthorized Practice of Midwifery, Criminally Negligent Homicide*, DEMOCRAT & CHRONICLE (Dec. 18, 2019, 11:43 AM), https://www.democratandchronicle.com/story/news/politics/albany/2019/12/17/yates-county-woman-charged-unauthorized-practice-midwifery/2677992001/ [https://perma.cc/4MV3-NJM2].

[295] Pager, *supra* note 19.

[296] Katie Sullivan Borrelli, *Sweeping Indictment Against Midwife Elizabeth Catlin Reduced to One Charge in Plea Deal*, DEMOCRAT & CHRONICLE (Sept. 16, 2021, 9:15 AM), https://www.democratandchronicle.com/story/news/2021/09/16/midwife-elizabeth-catlin-admits-1-count-94-other-charges-dropped/8263430002/ [https://perma.cc/YJ46-9AYD].

[297] John Christensen, *Midwife Liz Catlin Sentenced to Probation, Community Service*, Chronicle Express (Dec. 16, 2021, 5:03 AM), https://www.chronicle-express.com/story/news/2021/12/16/ny-midwife-liz-catlin-sentenced-probation-community-service/8914953002/ [https://perma.cc/K8GZ-XVQ8].

[298] Act of June 26, 1895, No. 263, § 1, 1895 Pa. Laws 373.

determining who was practicing, since he was required to distribute copies of the law to "each person who is known to him to act as midwife or nurse."[299] Then, in 1913, at the height of the debate over the "midwife problem" and citing "[t]he lives of many women and children [that] are needlessly sacrificed in childbirth . . . through the ignorance and incompetency of persons engaged in the practice of midwifery," Pennsylvania passed a law barring anyone other than a physician from practicing midwifery without a license.[300] This law was later repealed and replaced by a substantially similar law, the Midwife Regulation Act of 1929, which continues in effect today.[301]

Pennsylvania does have comparatively high community birth rates: in 2019, 1.9% of births took place in the home, and 1.2% took place in a birth center.[302] However, the legal environment is not as friendly to midwives and community birth as these figures may indicate at first glance. Pennsylvania is home to a substantial Plain population, whose families generally prefer out-of-hospital birth.[303] Also, many Pennsylvanians believe that non-nurse midwives are not illegal, but instead operate in a legal "gray area."[304]

Pennsylvania CNMs are regulated under the Medical Practice Act by both the Board of Nursing and the Board of Medicine; Pennsylvania is the only state with such a structure.[305] The Board of Medicine grants the midwife her nurse-midwifery license, but she must have already been licensed as a nurse by the Board of Nursing.[306] The Board of Medicine is made up of nine members, six of whom must be physicians.[307] A single seat on the board is reserved for a non-physician member, who can be a "nurse midwife,

---

[299] *Id.* § 3.

[300] Act of June 5, 1913, No. 294, 1913 Pa. Laws 441.

[301] 63 PA. CONS. STAT. §§ 171–76 (2021).

[302] NATALITY, 2007–2020 RESULTS, *supra* note 72.

[303] Linda Levinson, *Solving the Modern "Midwife Problem": The Case for Non-Nurse Midwifery Legislation in Pennsylvania*, 91 TEMPLE L. REV. 139, 179 (2018).

[304] *PA Law + Midwifery*, STEEL CITY HOMEBIRTH (2020), https://www.steelcityhomebirth.com/pa-law-midwifery [https://perma.cc/4NSK-9STE].

[305] MIDWIVES ALL. OF N. AM., *supra* note 156.

[306] 49 PA. CODE § 18.2 (2021).

[307] Medical Practice Act of 1985, Pa. L. 457, No. 112, § 3(a) (1985) (amended 2007).

physician assistant, certified registered nurse practitioner, respiratory therapist, licensed athletic trainer or perfusionist."[308] Midwives might not even have a seat at the table that determines their scope of practice. Instead, physicians are left to regulate the practices of their competitors.[309]

CNMs are required to file collaborative practice agreements with a physician in order to receive a license, which has had the practical effect of restricting their home birth attendance. Pennsylvania midwives have, through outreach and persistent lobbying, established a relatively congenial relationship with the state's obstetricians, who are generally willing to enter into collaborative agreements with CNMs who practice in hospitals and birth centers.[310] However, many refuse to enter into agreements with midwives who attend home births,[311] and the law still delegates to individual physicians the ability to define a midwife's specific scope of practice, even in areas for which her education and training have specifically prepared her.[312]

The requirement for collaborative agreements also has a negative impact on rural women. As hospitals consolidate services, many women have no choice but to travel for extended periods, often on winding back roads with limited phone reception, in order to obtain care.[313] Currently, 22% of Pennsylvania counties have no maternity care unit.[314] Entrepreneurial midwives are prevented from establishing birth centers in these locations

---

[308] *Id.*

[309] Note that this is a possible violation of antitrust law. *See* N.C. Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1117 (2015) (holding that state licensing boards do not have immunity from antitrust laws when a controlling number of decision-makers are active participants in the activity the board regulates, if the state is not engaged in active supervision of the board).

[310] Interview with Emily McGahey, *supra* note 159.

[311] *Id.*

[312] Medical Practice Act of 1985, *supra* note 307.

[313] *As Pennsylvania's Rural Delivery Rooms Close, Women Face No Choice but to Travel for Care*, 90.5 WESA (Oct. 27, 2017, 3:42 AM), https://www.wesa.fm/post/pennsylvanias-rural-delivery-rooms-close-women-face-no-choice-travel-care#stream/0 [https://perma.cc/R3VT-9B7C].

[314] Video: Policy Committee Hearing on Innovative Responses to Maternal Mortality (Senator Lisa Boscola Aug. 12, 2020), https://senatorboscola.com/policy-committee-hearing-on-innovative-responses-to-maternal-mortality/ [https://perma.cc/5Y35-HPF3] (statement by Nicole Chaney, Midwife, Reading Birth Center).

due to the requirement for a collaborative agreement and birth center-specific laws that require each birth center to have a physician serving as Director of Medical Affairs.[315]

Non-nurse midwives in Pennsylvania are regulated under the 1929 Midwife Regulation Law, which prohibits the practice of midwifery without a license.[316] As the state only licenses CNMs, all other midwives are practicing illegally, although enforcement is sporadic. In 2007, the Board of Medicine charged Diane Goslin, CPM with violating the Medical Practice Act.[317] After its hearing, the Board issued an order requiring Goslin to cease practicing midwifery and imposing penalties for practicing medicine and midwifery without a license, citing both the Medical Practice Act and the Midwife Regulation Law.[318] The Commonwealth Court of Pennsylvania reversed, but not because it found that Goslin did not violate the Midwife Regulation Law. Instead, it held that she had not been given proper notice of her violation of the Midwife Regulation Law because the Board had initially charged her only under the Medical Practice Act.[319] Although Pennsylvania has not subsequently enforced the Midwife Regulation Law, non-nurse midwives do not practice with the endorsement of the state. Because they are not licensed, midwives do not have access to life-saving medications. Diane Goslin herself later attended the birth of a baby who died because she was not able to provide the mother with antibiotics for a common infection.[320]

Pennsylvania in particular demonstrates the specific physical harm that can come to birthing people due to a state's failure to offer a pathway to licensure and autonomous practice to all types of midwives. As hospitals consolidate, women become further distanced from their care providers, and community midwives, who would be willing to fill in the gaps, are unable to provide critical emergency medications.

The history and method of regulating midwifery is unique to each state. These four examples represent four distinct statutory structures, regulatory schemes, enforcement

---

[315] 28 PA. CODE § 501.72 (2021).

[316] 63 PA. CONS. STAT. §§ 171–76 (2021).

[317] Goslin v. State Bd. of Med., 949 A.2d 372, 373 (Pa. Commw. 2008).

[318] *Id.* at 374.

[319] *Id.* at 377.

[320] Levinson, *supra* note 303, at 139.

mechanisms, and administrative tendencies that impact both the options of birthing people and their ability to safely experience community birth. Because each state varies in its hostility or ambivalence toward midwives, each state will require a different level of disruption and grassroots engagement if states are to adopt a regulatory structure more like New Mexico's or Washington's, described in Part II, *supra*. The current pandemic may provide that necessary disruption.

IV. The COVID-19 Pandemic's Effects on Birth: Challenges and Opportunities

While it has been difficult to achieve change within the maternal care system, the COVID-19 pandemic, which has shaken nearly every aspect of daily life, presents us with an opportunity to re-evaluate this system. For example, the prenatal appointment schedule, which, despite being implemented without evidence, had remained unchanged since it was first recommended in 1930,[321] persisted until the pandemic forced changes that minimized transmission of the virus and conserved healthcare resources.[322] After successful implementation of schedule updates in their own hospitals, some physicians now advocate for a full re-examination of the appointment schedule.[323] While it is unlikely that physicians and hospitals will advocate for a re-examination of the dominant medical model of care, midwives, families, and policymakers can take advantage of the pandemic's disruption of society to bring about much-needed changes to midwifery regulations and birthing choice.

Part IV will examine the myriad of ways that the pandemic has affected or could affect birth. Section IV.A presents the immediate impacts that the pandemic has had on birth, from governors' executive orders to decisions by individual hospital systems, and the recent increased demand for community birth. Section IV.B explains how this disruption could lead to changes in the system and how midwifery advocates can use the pandemic to their advantage.

A. The COVID-19 Pandemic's Direct Impacts on Birth

The COVID-19 pandemic has had an outsized effect on pregnant women. While other would-be hospital patients can postpone elective surgeries, pregnant people cannot simply wait it out. The pandemic has had a negative effect on new mothers in general: Perinatal

---

[321] Alex F. Peahl & Joel D. Howell, *The Evolution of Prenatal Care Delivery Guidelines in the United States*, 224 AM. J. OBSTETRICS & GYNECOLOGY 339 (2020).

[322] *Id.*

[323] *Id.* at 6–7.

depression rates have doubled, according to one Boston-area study.[324] Women who gave birth at the beginning of the pandemic were more likely to report feelings of failure, difficulty establishing breastfeeding, and fear of giving birth again in the future.[325] And the negative impact was not limited to pregnant women who planned to give birth: eleven states took advantage of the pandemic in order to restrict abortions. These states declared abortions elective or non-essential procedures and cited the need to conserve healthcare resources, despite opposition from healthcare providers themselves.[326] While restrictions that affected birthing women were often made in a good-faith effort to reduce transmission of the virus, they were made hastily and without due consideration of the impact that they would have on women in labor.

As the first wave of the coronavirus swelled in the United States, some hospitals, especially in New York City, banned visitors for all birthing people, despite evidence that support personnel are directly linked with shorter labors and a lower likelihood of a cesarean section (which are in turn associated with longer hospital stays).[327] These policies did not affect all women equally. Pregnant women with means were able to leave the city for other locations with less crowded hospitals or fewer restrictions.[328] COVID-positive women who were forced to birth alone were six times more likely to report the acute stress associated with a "traumatic childbirth" than COVID-positive women who were allowed a

---

[324] Pre-pandemic perinatal depression rates were 15–20% and increased to 36% during the pandemic. *COVID-19 May Deepen Depression, Anxiety, and PTSD Among Pregnant and Postpartum Women*, BRIGHAM AND WOMEN'S HOSP. (Dec. 1, 2020), https://www.brighamandwomens.org/about-bwh/newsroom/press-releases-detail?id=3743 [https://perma.cc/5WGB-3S6F].

[325] Carolina Mariño-Narvaez et al., *Giving Birth During the COVID-19 Pandemic: The Impact on Birth Satisfaction and Post-Partum Depression*, 153 INT. J. GYNECOLOGY & OBSTETRICS 83 (2021).

[326] Laurie Sobel et al., *State Action to Limit Abortion Access During the COVID-19 Pandemic*, KAISER FAM. FOUND. (Aug. 10, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/state-action-to-limit-abortion-access-during-the-covid-19-pandemic/ [https://perma.cc/F3N7-M9NH]. The bans are no longer in effect, either as a result of court order, settlement, or governor action lifting restrictions on elective procedures. *Id.*

[327] Van Syckle & Caron, *supra* note 13.

[328] Christina Caron & Katie Van Syckle, *Some Pregnant Women Who Can Afford to Are Fleeing New York City*, N.Y. TIMES (Apr. 1, 2020), https://www.nytimes.com/2020/04/01/parenting/pregnant-women-nyc-coronavirus.html [https://perma.cc/L6F9-48BX].

support person.[329] They also reported much higher levels of pain during delivery.[330] On March 28, 2020, the governor of New York issued an executive order that required all hospitals to allow all women in labor to be accompanied by one support person.[331] As of November 2021, many hospitals now allow two "visitors" so a birthing person is not forced to choose between a doula and a partner,[332] but some still keep strict caps or do not allow support people to trade in and out, which creates a particular hardship for families who already have children at home.[333]

Birthing women were also subject to harsh policies after giving birth, as the American Academy of Pediatrics[334] and the Centers for Disease Control and Prevention[335] recommended routine separation of infants from mothers with confirmed or suspected cases of COVID-19. Although the AAP described its guidance as "the most cautious recommendation,"[336] it proved disastrous. Mothers reported high levels of distress, and

---

[329] Gus A. Mayopoulos et al., *Giving Birth Under Hospital Visitor Restrictions: Heightened Acute Stress in Childbirth in COVID-19 Positive Women*, 11 SCI. REPS. 2 (Dec. 7, 2020), https://doi.org/10.1101/2020.11.30.20241026 [https://perma.cc/GH45-T3XG].

[330] *Id.* at 11.

[331] N.Y. Exec. Order No. 202.12 (Mar. 28, 2020), https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202.12.pdf [https://perma.cc/7KC5-R766].

[332] Temporary Changes to Services and Visitation Policy, MONMOUTH MED. CTR., https://www.rwjbh.org/monmouth-medical-center/patients-visitors/temporary-changes-to-services-and-visitation-pol/ [https://perma.cc/7A5E-YCX2].

[333] Visitor Policies and Guidance During COVID-19, MEDSTAR HEALTH, https://www.medstarhealth.org/about/visitor-policies-during-covid19 [https://perma.cc/4J8H-DY3Y]; Northside Hospital Visitation Guidelines, NORTHSIDE HOSP., https://www.northside.com/about/news-center/articles/2021/11/02/updated-northside-implements-visitor-restrict [https://perma.cc/WM6M-SCPM].

[334] Alyson Sulaski Wyckoff, *AAP Issues Guidance on Infants Born to Mothers with Suspected or Confirmed COVID-19*, AM. ACAD. PEDIATRICS (Apr. 2, 2020), https://www.aappublications.org/news/2020/04/02/infantcovidguidance040220 [https://perma.cc/LT7F-Q3YM].

[335] *Evaluation and Management Considerations for Neonates at Risk for COVID-19*, CDC (MAY 19, 2020), https://web.archive.org/web/20200520225823/https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-newborns.html [https://perma.cc/4HC3-P2SP].

[336] Alyson Sulaski Wyckoff, *Rooming-in, with Precautions, Now OK in Revised AAP Newborn Guidance*, AM. ACAD. OF PEDIATRICS (July 22, 2020), https://www.aappublications.org/news/2020/07/22/newbornguidance072220 [https://perma.cc/UY67-U9GL].

29% of mothers who intended to breastfeed were unable to do so after they had been reunited with their infants.[337] The policy may have also contributed to more severe symptoms of COVID-19; if the mother is positive for COVID-19 and her baby is taken from her, the associated stress response can worsen her illness.[338] The AAP[339] and CDC[340] revised their guidance in the summer of 2020 and now recommend that infants not necessarily be separated from their mothers, even if the mother tests positive. However, this does not prevent hospitals from enacting their own separation policies. Hospitals can still recommend separating infants and their COVID-positive mothers,[341] and the mothers may not be aware that they can decline this recommendation. One hospital in New Mexico even singled out women for COVID-19 testing based on whether they appeared to be Native American and separated these women from their babies for days while awaiting the return of test results.[342]

The pandemic also affected where women could give birth. While some women were able to voluntarily choose to change their birthing location, other women had decisions made for them as hospitals removed options for care. During the pandemic, many hospitals, although overwhelmed with COVID-19 patients, saw their revenues decrease as patients deferred elective surgeries or otherwise avoided the hospital.[343] In response to these

---

[337] Melissa C. Bartick et al., *Maternal and Infant Outcomes Associated with Maternity Practices Related to COVID-19: The COVID Mothers Study*, 16 BREASTFEEDING MED. 8 (2021), https://www.liebertpub.com/doi/pdf/10.1089/bfm.2020.0353 [https://perma.cc/63LZ-GDBD].

[338] Alison Steube, *Should Infants Be Separated from Mothers with COVID-19? First Do No Harm*, 15 BREASTFEEDING MED. 351, 351 (2020).

[339] Sulaski Wyckoff, *supra* note 334.

[340] *Evaluation and Management Considerations for Neonates at Risk for COVID-19*, CDC (Dec. 8, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-newborns.html [https://perma.cc/WA5E-YPVH].

[341] *Having a Baby During the Coronavirus Outbreak FAQs*, UVA HEALTH, https://uvahealth.com/services/covid19/birth-coronavirus-faqs [https://perma.cc/YKR9-UJDX] ("If you have tested positive for COVID-19 or we suspect you're infected, we'll talk with you about separating you from your baby to prevent neonatal infection.").

[342] Bryant Furlow, *A Hospital's Secret Coronavirus Policy Separated Native American Mothers from Their Newborns*, PROPUBLICA (June 13, 2020, 5:00 AM), https://www.propublica.org/article/a-hospitals-secret-coronavirus-policy-separated-native-american-mothers-from-their-newborns [https://perma.cc/PQ9Y-6VVT].

[343] *Hospitals and Health Systems Face Unprecedented Financial Pressures Due to COVID-19*, AM. HOSP. ASS'N (May 2020), https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due [https://perma.cc/A5VL-UQYG].

decreased revenues, regional healthcare centers closed or consolidated maternity units and hospital-affiliated birth centers,[344] amplifying the need for free-standing, midwife-led birth centers. COVID-19 vaccine requirements have also affected already limited hospital staffing, with at least one hospital in upstate New York closing its maternity ward as a direct result of nurses and other staff choosing to resign rather than be vaccinated.[345]

The demand for home birth services has exploded nationwide since the beginning of the pandemic, with some community-setting midwives attending twice the typical number of births per month.[346] Although access to midwives is often limited to those who can pay out of pocket, one group of Pennsylvania midwives turned to crowd-funding to assist low-income Philadelphia families who wanted to avoid the hospital.[347] Even women who experienced complications during earlier pregnancies began to research how to give birth at home and made contact with community midwives. Careen Goebig, a Pennsylvania woman whose older son was born with the aid of vacuum suction after she was given a Pitocin induction and an unwanted epidural, decided in late March to pursue a home birth with a CPM.[348] She had been planning on delivering in the hospital with a CNM until one of her last prenatal appointments, when she became gripped by fear of contracting the virus.[349] At the appointment, Ms. Goebig spoke with one of the hospital's CNMs about her concerns.[350] Ms. Goebig expected the CNM to "instill some fear" and urge her to continue

---

[344] Harold Brubaker, *Tower Health is Cutting 1,000 Jobs as Coronavirus Losses Mount*, PHILA. INQUIRER (June 16, 2020), https://www.inquirer.com/business/health/tower-health-hospital-layoffs-covid-19-20200616.html [https://perma.cc/U27Z-Y27E].

[345] John Yoon, *A Small Upstate New York Hospital Will Stop Delivering Babies After 6 Workers Quit Rather Than Be Vaccinated*, N.Y. TIMES (Sept. 24, 2021), https://www.nytimes.com/2021/09/13/nyregion/upstate-ny-hospital-stop-delivering-babies.html [https://perma.cc/FA5J-Y2BP].

[346] Sophie Burkholder, *COVID-19 Sparked a Rising Interest in Home Births, But Not All Can Afford Them*, PHILA. INQUIRER (July 13, 2020), https://www.inquirer.com/news/midwife-midwives-birth-covid-babies-delivery-20200712.html [https://perma.cc/M8Y8-DGRN].

[347] *Id.*

[348] Wendy Ruderman, *Fearing Coronavirus at Hospitals, These Pregnant Women Would Rather Give Birth at Home, Despite Risks*, PHILA. INQUIRER (Apr. 18, 2020), https://www.inquirer.com/health/coronavirus/pregnant-philadelphia-penn-insurance-home-birth-midwife-coronavirus-20200416.html [https://perma.cc/99YS-LT6T].

[349] *Id.*

[350] *Id.*

planning to give birth in the hospital, but instead, "she took a seat and started naming some midwives she would recommend for home births."[351]

Although nationwide data is not yet available for 2020, as of October 2021, preliminary state-level data from the few states that have made it available suggest that the increased demand for community birth is supported by statistics and was not merely a perception. In 2020, 2,887 home births took place in Pennsylvania,[352] up from 2,606 in 2019.[353] Similar increases were seen in California.[354] Given that the total number of births decreased in 2020,[355] this indicates that the rate of home birth increased significantly in 2020.

B. Advocating for Change in the Wake of the Pandemic

The pandemic is not the first time that a disaster has provided an opportunity to reexamine the country's maternal healthcare system. During Hurricane Katrina, which slammed the United States' Gulf Coast in August 2005 and caused hundreds of deaths and billions of dollars of damage in a matter of days, babies came anyway. Women labored while preparing for evacuations, mourned the loss of their social support structure after fleeing New Orleans, and gave birth in hospitals so crowded "the babies were getting stacked."[356] Physicians were also evacuated separately from their patients and women had no access to their own medical information.[357] After Katrina, activists urged the inclusion

---

[351] *Id.*

[352] BIRTH STATISTICS, PA. DEP'T OF HEALTH, https://www.health.pa.gov/topics/HealthStatistics/VitalStatistics/BirthStatistics/Pages/birth-statistics.aspx [https://perma.cc/FKS5-GL4L] (click "Show+" to the right of "Preliminary Statistics." Download "Preliminary Pennsylvania residence birth data" and open "preliminary-month-place-2020.csv.").

[353] BIRTHS: FINAL DATA FOR 2019, 70 NAT'L VITAL STATS. REPS. 1, 6 (2021), https://www.cdc.gov/nchs/data/nvsr/nvsr70/nvsr70-02-tables-508.pdf [https://perma.cc/UE3S-LS4B].

[354] Kaiser Health News, *Out-of-Hospital Births Gain Popularity in 'Baby Bust' Decade*, U.S. NEWS (Sept. 22, 2021), https://www.usnews.com/news/health-news/articles/2021-09-22/home-births-gain-popularity-in-baby-bust-decade [https://perma.cc/25W9-4P54].

[355] *Id.*

[356] Roshan Badakhsh et al., *The Childbearing Experience During a Natural Disaster*, 39 J. OBSTETRIC, GYNECOLOGIC & NEONATAL NURSING 489, 493 (2010).

[357] Rama Lakshmi, *Group Urges Disaster Planning for Women, Babies*, WASH. POST (Aug. 17, 2006), https://www.washingtonpost.com/archive/politics/2006/08/17/group-urges-disaster-planning-for-pregnant-women-babies/a96cc280-a7e0-4daf-a2ea-8d66feab5a5e/ [https://perma.cc/ZP2Q-FCW6].

of pregnant women and newborns into future disaster preparedness plans. In a statement that now feels oddly prescient, one midwife who headed ACNM's disaster preparedness efforts said, "In fact, if there is a pandemic flu, a hospital is not where you take a pregnant woman or an infant to."[358]

Despite these warnings, little has changed, and the United States' maternal care system remains poorly integrated. However, there may be reason to hope that the response after the COVID-19 pandemic will differ from the response following Hurricane Katrina. First, the pandemic has directly affected the entire nation, whereas during Hurricane Katrina those who did not live on the Gulf Coast could have easily dissociated from the disaster and pretended that a similarly catastrophic event could not occur elsewhere. The coronavirus offers no such psychological escape hatch. Additionally, the pandemic has lasted much longer than a hurricane, which may allow greater momentum to build in the community birth movement.

As the pandemic has unfolded, pregnant women who were planning to deliver in a hospital have reassessed their options,[359] and the response from the medical industry has been generally unfavorable. Some obstetricians have advised that a physician's ethical duty is to continue recommending the hospital as the safest birth setting.[360] The American Association of Pediatricians took a slightly softer stance, issuing guidance for the care of infants born at home, but still explicitly "not recommend[ing] planned home birth."[361] Advocates of maintaining the hospital birth status quo argued in particular that the public health crisis associated with the pandemic could make planned home birth more dangerous in the event of complications, since normally available ambulances could be busy

[358] *Id.*

[359] Theresa E. Gildner & Zaneta M. Thayer, *Birth Plan Alterations Among American Women in Response to COVID-19*, 23 HEALTH EXPECTATIONS 969, 969 (2020).

[360] Grünebaum et al., *Professionally Responsible Counseling About Birth Location During the COVID-19 Pandemic*, 48 J. PERINATAL MED. 450, 450 (2020). Note that the article's author was also the author of the studies he cites to demonstrate the dangers of community birth.

[361] Kristi Watterberg, *Providing Care for Infants Born at Home*, 145 PEDIATRICS 1, 1 (May 2020), https://pediatrics.aappublications.org/content/pediatrics/145/5/e20200626.full.pdf [https://perma.cc/MUE4-HFHX].

transporting coronavirus patients.[362] However, most transfers from home births to the hospital are for non-urgent reasons, such as a desire for pain relief.[363]

Midwives in several states petitioned governors to grant emergency licensure to CPMs.[364] While most lobbying efforts were unsuccessful, New York granted emergency authorization for midwives licensed out-of-state to practice in New York,[365] which could be interpreted as allowing licensed CPMs to practice during the pandemic. Women who are able to give birth during the pandemic with a CPM in attendance may not be willing to give that up following the termination of the state of emergency, and they could be inspired to lobby for updated regulations or statutes. In both the New York Senate[366] and Assembly,[367] new bills have been introduced that would explicitly allow CPMs to obtain a professional license in the state. In Georgia, ten senators have sponsored the Georgia Community Midwife Act, which would create a state board of community midwifery and allow CPMs to practice in the state.[368]

New York has also removed some bureaucratic hurdles that previously prevented midwives from establishing birth centers. In 2018, New York State had only three birth centers.[369] Even though the legislature amended the law in 2016 to allow midwives to run

---

[362] Katharine Gammon, *Should You Have a Homebirth Because of Coronavirus?*, N.Y. TIMES (Apr. 18, 2020), https://www.nytimes.com/2020/03/30/parenting/home-birth-coronavirus-hospital.html [https://perma.cc/A44R-TLPZ] ("Dr. Han said that during the coming months of a public health crisis, ambulance service could be slowed down, and blood supply could run low, making it potentially dangerous for a woman trying to have a home birth to transfer to a hospital.").

[363] Kenneth C. Johnson & Betty-Anne Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1, 2 (June 16, 2005), https://www.bmj.com/content/bmj/330/7505/1416.full.pdf [https://perma.cc/6RWW-A35Q].

[364] Adelle Dora Monteblanco, *The COVID-19 Pandemic: A Focusing Event to Promote Community Midwifery Policies in the United States*, 3 SOC. SCI. & HUMANS. OPEN, 2021, at 4, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7775796/ [https://perma.cc/Y66B-BHFZ].

[365] N.Y. Exec. Order No. 202.11 (Mar. 27, 2020), https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO_202_11.pdf [https://perma.cc/VZ9R-KR2E].

[366] S.B. 7078, 204th Leg., 2021-2022 Reg. Sess. (N.Y. 2021).

[367] H.B. 7898, 204th Leg., 2021-2022 Reg. Sess. (N.Y. 2021).

[368] S.B. 111, 156th Leg., 2021-2022 Reg. Sess. (Ga. 2021).

[369] Satow, *supra* note 289.

birth centers independently,[370] the Department of Health delayed drafting the regulations necessary to implement the statute. Finally, in 2020, under pressure due to the COVID-19 pandemic, the Department of Health issued temporary licenses for two midwife-led birth centers.[371] Women who have the opportunity to give birth at one of these newly-licensed facilities may be unlikely to accept a reduction in community birth options in the future.

In addition to the pandemic's effects on midwifery regulation in New York, there is nationwide opportunity for change as the pandemic may alter the public's perception of which birthing locations are safe. The medical industry's success in preventing expanded access to midwifery and community birth has generally been predicated on emotional arguments that detail the things that can go wrong in home birth, even if those things are exceptionally unlikely to happen. However, the pandemic has made many people more fearful of giving birth in hospitals than in their homes. People are delaying surgeries out of fear of the virus,[372] and women who were originally seeking hospital births at the urging of their partners are finding that those partners are now encouraging community births.[373] The fear-based arguments that sustained strict limitations on midwives' practices may not be as successful in the future, and midwives and their advocates may be able to deploy their own fear-based arguments in order to win greater autonomy.

The increase in demand for community midwifery care will also have a ripple effect on the perceptions of midwives. Those who give birth in a community setting with a midwife present will likely share their experiences with others. Given that individuals who know someone who has had a midwife-attended birth are more likely to view midwives in a positive light,[374] increasing the number of people who share their community birth stories will likely also increase the number of people who see community birth, and home birth in

---

[370] *Id.*

[371] *Governor Cuomo & COVID-19 Maternity Task Force Chair Melissa DeRosa Announce Increased Access to Midwife-Led Birth Centers Amid COVID-19 Pandemic*, GOV. KATHY HOCHUL PRESSROOM (June 16, 2020), https://www.governor.ny.gov/news/governor-cuomo-covid-19-maternity-task-force-chair-melissa-derosa-announce-increased-access [https://perma.cc/4YC7-APE3].

[372] Jane E. Brody, *Should I Have Elective Surgery in the Pandemic?*, N.Y. TIMES (Dec. 21, 2020), https://www.nytimes.com/2020/12/21/well/live/elective-surgery-pandemic.html [https://perma.cc/6NH2-ETK7].

[373] Interview with Emily McGahey, *supra* note 159; de Freyas-Tamura, *supra* note 17.

[374] Peter G. Johnson & The Midwifery Research Project Group, *Midwife and Nurse-Midwife: The Effect of Title on Perception and Confidence in Services Provided by Professional Midwives*, 43 J. NURSE-MIDWIFERY 296, 302 (1998).

particular, as a normal, legitimate choice rather than a fringe practice. As a result, legislators may be less likely to believe arguments like the one presented to Nebraska's legislature in 1998 (that home birth is something that only happens in so-called "Third World" countries) if they are increasingly likely to personally know families who have experienced community birth.

CONCLUSION

Women in the United States often do not have choices in birthing location, and 98% will give birth in a hospital where their ability to exercise autonomy during the birth process itself is further restricted. Regulations restricting the practice of midwifery, coupled with laws that do not allow midwives to be reimbursed for their services, contribute to the dominance of physician-attended, hospital-based birth. States need to make a number of statutory and regulatory changes to their maternal healthcare system, including creating a path to licensure for certified midwives and certified professional midwives; removing requirements for physician oversight; establishing autonomous Boards of Midwifery, which must have representation from all categories of licensed midwives; establishing systems of safe and respectful transfer of care between a community setting and the hospital; and requiring Medicaid and private insurance to reimburse midwives and birth centers. States should also recognize the historic marginalization of midwives and remove bureaucratic barriers that require midwives to prove themselves as a "new" profession.

The COVID-19 pandemic may be the seminal moment that finally leads to the change that midwives and their advocates need. Midwives report exponential increases in demand for their services, as women seek to avoid hospitals out of fear of the disease and fear of hospital-imposed restrictions on labor support. The marginalization of midwives over the past three centuries was made possible by fear, but midwives and their clients now have an opportunity to take advantage of changing perceptions and take back birth.