

# TO BECOME A MIDWIFE: REDUCING LEGAL BARRIERS TO ENTRY INTO THE MIDWIFERY PROFESSION

## I. INTRODUCTION

At the turn of the twentieth century, midwife Hanna Porn served the Finnish, Russian, and Swedish working class immigrants of Gardner, Massachusetts.<sup>1</sup> For less than a third of what local doctors charged for delivery, she attended mothers throughout labor and delivery.<sup>2</sup> During the week after childbirth, she returned each day to check on each mother and baby and to do cooking and some cleaning.<sup>3</sup> Moreover, the babies she delivered were twice as likely to survive as babies delivered by local doctors.<sup>4</sup> Then, on July 27, 1905, Hanna Porn became a target of the era's campaign to eliminate the profession of midwifery.<sup>5</sup> Charged with the criminal act of illegally practicing medicine, she paid many fines, spent three months in jail, and endured ten trials during the next four years.<sup>6</sup> Throughout her ordeal, Hanna remained unwavering in her commitment to safer, more comprehensive, and affordable maternity care in her community.<sup>7</sup> Her 1913 obituary noted that she was employed as a "private nurse" at an address where, according to local vital records, a baby boy was born on the day she died.<sup>8</sup>

Although Hanna Porn practiced almost a century ago, her experience resonates today. Data show that babies delivered by midwives are still

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1. See Eugene R. Declercq, *The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts*, 84 AM. J. PUB. HEALTH 1022, 1023 (1994) [hereinafter Declercq, *Hanna Porn*]. This article cites several cases, including *Commonwealth v. Porn*, 82 N.E. 31 (Mass. 1907). Modern cases holding that midwifery constitutes the illegal practice of medicine continue to cite *Porn* for the proposition that "[a]lthough childbirth is not a disease, but a normal function of women, . . . the practice of medicine does not appertain exclusively to disease, and obstetrics as a matter of common language [sic] has long been treated as a highly important branch of the science of medicine." *Bowland v. Municipal Court*, 556 P.2d 1081, 1084 (Cal. 1976) (citing *Crees v. California State Board of Medical Examiners*, 213 Cal. App. 2d 195, 212 n.8 (Cal. Ct. App. 1963) (citing *Porn*, 82 N.E. at 31)).

2. Declercq, *Hanna Porn*, *supra* note 1, at 1023.

3. For a summary of the findings showing improved outcomes of pregnancy for midwife-attended childbirth compared to physician-attended child birth see note 9.

4. See *id.* at 1027.

5. *Id.* at 1022-24. For a historical overview of the early twentieth century campaign against midwifery, see JUDY BARRETT LITOFF, *AMERICAN MIDWIVES, 1860 TO THE PRESENT* 56, 64-90 (1978).

6. Declercq, *Hanna Porn*, *supra* note 1, at 1022, 1024-27.

7. See *id.* at 1027.

8. *Id.*

more likely to survive than comparable babies delivered by doctors.<sup>9</sup> Like Hanna Porn, modern midwives describe their practice as providing more comprehensive maternity care than doctors provide, including more emotional and spiritual support.<sup>10</sup> Additionally, midwives provide lower cost care and often serve women who have no access to physician or hospital care.<sup>11</sup> Today, midwives still face hostility and legal barriers to practice.<sup>12</sup>

Hanna Porn's classification as a criminal resulted from a confluence of social, cultural, political, and legal forces. Of these forces, the law provides the crucial structure that determines whether midwifery thrives, or suffocates.<sup>13</sup> Early twentieth century efforts, led by obstetricians, to

9. See, e.g., Marian F. MacDorman & Gopal K. Singh, *Midwifery Care, Social and Medical Risk Factors, and Birth Outcomes in the USA*, 52 J. EPIDEMIOLOGY AND COMTY. HEALTH 310 (1998). A comprehensive 1991 study of midwife-attended and physician-attended childbirths in America controlled for social and medical risk factors. The study analyzed "all singleton, vaginal births at 35-43 weeks gestation delivered by either physicians or certified nurse midwives in the United States in 1991." *Id.* at 311. The study found that midwife-attended births had a 19% lower risk of infant death, a 33% lower risk of neonatal mortality, and a 31% lower risk of low birth weight, than physician-attended births. *Id.* The study analyzed outcomes in childbirths attended by nurse midwives, not direct-entry midwives. *Id.* The midwives' success rate is particularly noteworthy because their patients have a higher risk of poor birth outcomes because of socio-demographic risk factors than physicians' patients do. *Id.* at 314. Compared to similar physician-attended births, midwife-attended births have lower rates of medical interventions such as caesarean sections, vacuum and forceps deliveries, induced labor, ultrasound, and fetal monitoring. *Id.* at 310.

The practice of nurse midwifery has been highly scrutinized. Dozens of epidemiological and clinical research studies document the quality, safety, and cost-effectiveness of the nurse midwifery practice. This rich literature is due, in no small part, to the association of nurse midwifery education with academic medical centers and to the skepticism and hostility that the profession continues to combat. See generally American College of Nurse-Midwives, *Resources and Bibliography: Quality and Effectiveness of Nurse-Midwifery Practice*, at <http://www.acnm.org/prof/display.cfm?id=72> (July 19, 2000).

In contrast, documentation of the safety and quality of direct-entry midwifery practice in the United States is sparse. Because most direct-entry midwives attend births in homes rather than hospitals, much of the literature examines the variable of location rather than the variable of birth attendant. However, at least six studies published in peer-reviewed journals found that planned home births attended by lay midwives compared favorably with physician-attended births. See generally American College of Nurse-Midwives, *Resources and Bibliography: Quality and Safety of Direct-Entry Midwifery Practice in the U.S.*, at <http://www.acnm.org/prof/display.cfm?id=73> (Feb. 16, 2000).

10. For a description of the midwifery model of care and its spiritual, emotional, medical, and economic advantages, see C.M. DOWER ET AL., PEW HEALTH PROFESSIONS COMMISSION AND THE UCSF CENTER FOR THE HEALTH PROFESSIONS, *CHARTING A COURSE FOR THE 21ST CENTURY: THE FUTURE OF MIDWIFERY 2-5* (1999).

11. For one analysis of midwifery and health care costs, see OFFICE OF TECHNOLOGY ASSESSMENT, U.S. CONGRESS, *NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE-MIDWIVES: A POLICY ANALYSIS 49* (1986).

12. See Part I of this Note for a description of some of the legal barriers, the hostility that often accompanies the laws, and their impact on midwives and their patients.

13. See generally Eugene R. Declercq et al., *State Regulation, Payment Policies, and Nurse-Midwife Services*, HEALTH AFFAIRS, Mar.-Apr. 1998, at 190, 198 [hereinafter Declercq, *State*

eliminate midwifery established numerous legal barriers to practice. Like Massachusetts, some states banned midwifery outright and continue to criminalize direct-entry midwifery today.<sup>14</sup> Legal obstacles to the practice of nurse midwifery include statutes and regulations that prohibit physicians from practicing with more than one or two midwives,<sup>15</sup> require direct physician supervision,<sup>16</sup> prevent nurse midwives from directly billing for services provided under Medicaid and Medicare,<sup>17</sup> unnecessarily limit the prescriptive authority of nurse midwives,<sup>18</sup> or allow hospitals to deny nurse midwives admitting privileges.<sup>19</sup> Ultimately, however, the laws with the most profound impact are those governing a midwife's ability to enter into the profession in the first place.

This Note discusses the legal prerequisite to widespread access to midwifery:<sup>20</sup> state laws regulating entry into the profession. Part II

*Regulation*] (documenting the relationship between specific regulations and the prevalence of midwifery practice in states).

14. See, e.g., VA. CODE ANN. § 32.1-147 (MICHIE 1997).

15. LA. ADMIN. CODE tit. 46, § 4513.C.5.k (1999) ("A physician may enter into a collaborative practice agreements for the exercise of limited prescriptive authority with not more than two (2) [CNMs]."). The Louisiana Code allows the administrative body to develop guidelines for allowing exceptions to the 1:2 ratio. This 1:2 ratio contrasts with the higher 1:4 maximum ratio Medicare stipulates for teaching physicians and residents in training. 42 C.F.R. § 415.174(a)(3)(2000).

16. See, e.g., IDAHO CODE § 23.01.01.280.03 (MICHIE 2000) ("The certified nurse-midwife shall practice with supervision . . ."). Contrast this language with the New Mexico regulation that states, "The CNM . . . provides for consultation and collaborative management with, or referral to other members of the health care team, including physicians, as indicated by the health status of the client." N.M. ADMIN. CODE tit. 16, § 11.2.9.1 (2000).

17. Some states have addressed this issue by writing regulations that explicitly permit direct billing and reimbursement of nurse midwives. See, e.g., CONN. AGENCIES REGS. § 17b-262-581 (1998).

18. For a general discussion of the issue of nurse midwives' prescriptive authority, see Karen Fennell, *Prescriptive Authority for Nurse-Midwives: A Historical Review* (1991) (unpublished manuscript, on file with author). See also Report of the Council on Medical Service on Non-Physician Prescribing, American Medical Association, CMS Report 11-I-99 (Dec. 1999), at <http://www.ama-assn.org/meetings/public/interim99/reports/cmsrpts/rtf/cmsrep11.rtf>.

19. A diverse and extensive body of literature addresses the denial of hospital staff privileges, not only to nurse midwives, but also to other health providers. See Tim A. Thomas, Annotation, *Denial by Hospital of Staff Privileges or Referrals to Physician or Other Health Care Practitioner as Violation of Sherman Act* (15 U.S.C.A. §§ 1 et seq.), 89 A.L.R. FED. 419 (1988); Joseph Mark Saponaro, Note, *Determining the Immunity "Measuring Stick": The Impact of the Health Care Quality Improvement Act and Antitrust Laws on Immunity Aspects of Granting Privileges to Physician Assistants*, 47 CLEV. ST. L. REV. 115, 127-32 (1999) (analyzing cases related to the denial of hospital privileges to nurse midwives). Some jurisdictions prohibit such discrimination against nurse midwives and their supporters. See, e.g., 2001 D.C. Stat. 44-507(b)(4) ("The following are not valid factors for consideration in the determination of qualifications for staff membership or clinical privileges: . . . An applicant's support for, training of, or participation in a private group practice with members of a particular class of health professionals.").

20. This Note restricts its discussion to midwifery care provided to women and their infants throughout pregnancy, childbirth, and the postpartum period. However, midwives, notably nurse midwives, provide a much wider range of services to women both during their childbearing years and

provides history and background regarding midwives' current legal status. First, the Note describes midwifery and its public health benefits. The Note then discusses one critical barrier, the regulation of entry into the profession of midwifery through licensing, registration, or criminalization, and through judicial decisions that permit, restrict, or criminalize direct-entry midwifery.

Part III analyzes the impact of overly strict licensure laws and other midwifery restrictions on the nation's public health. The section also discusses the ineffectiveness of using litigation to establish entry requirements to protect the public from incompetent midwives and improve the well-being of pregnant women and infants.

Part IV proposes that the time is ripe for states to adopt legislation that unifies regulation of entry into the professions of both nurse midwifery and direct-entry midwifery through a bifurcated process. This process should closely tie entry requirements to those skills and knowledge necessary for quality midwifery care. Proposed legislation would provide state entry requirements that meet, but do not exceed, requirements for national midwifery certification.

## II. HISTORY AND OVERVIEW

The role of midwives in improving pregnancy outcomes makes the profession's current legal status substantially important to American public health. States regulate two branches of midwifery, either through statute and regulation or through judicial decisions. All states regulate entry of nurse midwives into their profession by statute or regulation. Entry requirements for direct-entry midwives may be statutory, regulatory, judicial, or may be legally ambiguous.

### *A. Public Health Benefits of Midwifery*

Research reported during the last several decades documents that midwife-attended childbirth yields broad public health benefits, both in terms of individual health benefits and the society-wide social and economic benefits.<sup>21</sup> The midwifery model of care, with its focus on the normalcy of the pregnancy and childbirth experience,<sup>22</sup> contrasts with the

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during the following years.

21. For a summary of some of this research, see *supra* note 9 and accompanying text.

22. See DOWER, *supra* note 10, at 5. Dower provides an overview of midwifery in the United States, makes policy recommendations in five areas, and contrasts the midwifery model of maternity care with the medical model of care. *Id.* at 1-44.

medical, or obstetric, model of care, which focuses on pathology and its prevention and hence often leads to obstetric intervention in childbirth.<sup>23</sup>

Today, two branches of midwives, direct-entry midwives and nurse midwives, coexist in the United States. Both branches emphasize the overall well-being of women throughout the childbearing cycle, individualized care, continuous support, and minimal technological intervention.<sup>24</sup> Direct-entry midwives become midwives primarily through apprenticeship and self-teaching<sup>25</sup> and generally provide maternity care in clients' homes.<sup>26</sup> Nurse midwives are nurses with advanced training in midwifery.<sup>27</sup> Nurse midwives provide maternity care, well-woman care, and family planning services, generally working in hospitals or birth centers.<sup>28</sup>

National organizations certify direct-entry midwives and nurse midwives. The North American Registry of Midwives (NARM) administers a national testing and certification process for direct-entry midwives known as the Certified Professional Midwife.<sup>29</sup> The American

23. *Id.* at 2. National statistics show that in 1997 20.8% of all births were by Cesarean section, 83% were monitored electronically, and 18% of labors were induced, and show that childbirth is largely a medical, not a normal event in the United States. Sally C. Curtin & Melissa M. Park, *Trends in the Attendant, Place, and Timing of Births, and in the Use of Obstetric Interventions: United States, 1989-97*, 47 NATIONAL VITAL STATISTICS REPORTS, (Centers for Disease Control and Prevention, Hyattsville, Md.) Dec. 2, 1999, at 4.

24. DOWER, *supra* note 10, at 4.

25. For a history of midwifery in the United States, see generally LITOFF, *supra* note 5, at 122-34. Historically, women learned the art of midwifery through apprenticeship, often from their mothers or grandmothers. Midwives practiced independently and were recognized as community healers. Traditional apprenticeships, where mother passed the art to daughter, declined throughout the twentieth century. See generally *id.* at 48-64. Today, many direct-entry midwives enter their profession through apprenticeship or self-teaching. A number of midwifery schools, including schools accredited by the Midwifery Education Association Counsel and the American College of Nurse Midwives, provide training for direct-entry midwives. Many direct-entry midwives speak of being called to the vocation. For reports of interviews with Missouri direct-entry midwives, see generally Ann Swearingen Newman, *The Missouri Midwives Association: The Persistence of a Social Movement Organization in an Inhospitable Environment* 97, 108, 114, 142, 158 (1995) (unpublished Ph.D. dissertation, University of Missouri-Columbia) (on file with the University of Missouri-Columbia Library).

26. DOWER, *supra* note 10, at 6.

27. See generally LITOFF, *supra* note 5, at 122-26. With the medical campaign to eliminate traditional midwifery came efforts to improve maternity care for women who would not have access to physicians, including urban and rural poor. A St. Louis physician, Fred J. Taussig, first suggested establishing midwifery schools for nurses. *Id.* at 122. In 1918, the Maternity Center Association opened in New York City. *Id.* at 123. In 1925, Frontier Nursing Service began in rural Kentucky. *Id.* at 125. Today, forty-six education programs exist for nurse midwives and over 7,000 nurse midwives earned the credential, Certified Nurse Midwife. DOWER, *supra* note 10, at 6.

28. DOWER, *supra* note 10, at 5-6.

29. THE NORTH AMERICAN REGISTRY OF MIDWIVES, THE CERTIFIED PROFESSIONAL MIDWIFE (CPM), 1998. NARM is an independent organization with ties to the Midwives Alliance of North

College of Nurse-Midwives (ACNM) Certification Council (ACC) administers a certification process for nurse midwives, the Certified Nurse Midwife (CNM).<sup>30</sup> Although the two branches of midwifery both focus on the normalcy of childbearing and women's empowerment, they have profound differences in philosophy, tradition, and scope of practice that affect their ability to work together.<sup>31</sup>

Midwifery has society-wide implications for community well-being and for more rational allocation of health care resources. Dozens of studies detail the medical benefits of midwife-attended birth.<sup>32</sup> The most significant of the many medical benefits is a substantially reduced infant and neonatal mortality rate among midwife-attended births as compared to similar births attended by physicians.<sup>33</sup>

Society-wide social and economic benefits result from fewer low birth weight babies and their associated short and long term medical and psychological complications, as well as from reduced medical

America (MANA), the national professional organization of direct-entry midwives. The CPM process recognizes multiple routes of entry into the profession, including apprenticeship. Certification requires the successful completion of both a written examination and a hands-on skills assessment of an applicant's mastery of a core set of competencies. *Id.* See also LEGIS. COMMITTEE ON NEW LICENSING BOARDS, ASSESSMENT REPORT FOR CERTIFIED PROFESSIONAL MIDWIVES S. 875 (N.C. 2000); DIRECT ENTRY MIDWIFERY STUDY COUNCIL, FINAL REPORT AND RECOMMENDATIONS, 122nd General Assembly (Ohio 1998). Citizens for Midwifery commissioned experts in competency-based education to evaluate NARM's certification process. The experts concluded that the Certified Professional Midwife program "clearly exhibits all the required characteristics of a competency-based program." Deborah Bingham Catri, *Testimony Regarding Competency-based Education and an Assessment of Whether the Certified Professional Midwife (CPM) Process is in Fact Competency-based*, at <http://www.narm.org/Catri.htm> (July 1997).

30. DOWER, *supra* note 10, at 6. Note that in 1996, ACC adopted certification for direct-entry midwives, the Certified Midwife. *Id.* at 7. Certification as a nurse midwife requires formal education as a registered nurse plus additional university-based education in midwifery. *Id.* at 5. A masters degree is not required and 30% of CNMs do not have a masters degree. Alyson Reed, *State Mandated Masters Degrees*, STRATEGIES FOR INFLUENCING STATE POLICY (Am. C. Nurse-Midwives, Washington, D.C.), Sept. 1998, at <http://www.midwife.org/legis/display.cfm?id=175>. Of those with masters degrees, many have Masters of Arts, Public Health, or Midwifery granted by schools of medicine, public health, or midwifery. *Id.* All have passed ACC's examination of clinical competencies. *Id.*

31. See generally Judith P. Rooks, Editorial, *Unity in Midwifery? Realities and Alternatives*, 43 J. NURSE-MIDWIFERY 315, 318-19 (1998) (analyzing current and potential future relationships between the two branches of midwifery, noting the differences between the two, commenting on the difficulty in bridging these differences, and predicting future development along "parallel paths with mutual collaboration and support in areas that don't threaten the principles and well-being of either group").

32. For listings of more than a dozen of these studies, see *Resources and Bibliography: Quality and Effectiveness of Nurse-Midwifery Practice*, *supra* note 9, and *Resources and Bibliography: Quality and Safety of Direct-Entry Midwifery Practice in the U.S.*, *supra* note 9.

33. See MacDorman, *supra* note 9, at 310.

interventions and their attendant complications and costs.<sup>34</sup> The fact that midwives traditionally practice in underserved rural and urban areas increases midwives' positive societal impact.<sup>35</sup> Two prominent independent public policy organizations conducted comprehensive analyses of the potential impact of midwifery care on the American health care system.<sup>36</sup> Based on their findings of significant social and economic benefit, both organizations recommended that specific policy changes be made at the state and federal levels to expand the practice of midwifery in the United States.<sup>37</sup>

### *B. State Regulation of Entry into the Midwifery Profession*

The personal and public health advantages of midwifery occur only when midwives enter the profession and practice.<sup>38</sup> Although federal policy influences the practice of midwifery,<sup>39</sup> the states regulate entry, or

34. *Id.* at 310.

35. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 11, at 6. Midwives, who are more willing than physicians to practice in underserved rural and urban areas, contribute to improved geographic distribution of health care. *Id.* For a policy analysis of the social and economic benefits midwifery offers the American health care system, see OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 11. This 1986 study assessed the role of CNMs in the national health system and the potential impact on CNM practice of changing federal policy, particularly with relation to health care financing.

36. See OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 11, and DOWER, *supra* note 10.

37. See OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 11, at 10-12, and DOWER, *supra* note 10, at i-v. In 1996, the UCSF Center for Health Professions midwifery task force found that "the midwifery model of care is an essential element of comprehensive health care for women and their families that should be embraced by, and incorporated into, the health care system and made available to all women." DOWER, *supra* note 10, at i. The task force made fourteen recommendations in five areas, including state regulation and credentialing. See *id.* at i-v.

38. See generally Declercq, *State Regulation*, *supra* note 13, at 197-98 (noting that the friendliness or hostility of a state's regulatory climate quantifiably affects the extent to which midwives practice in that state).

39. Although historically, public health regulation is a state matter, federal policy influences midwifery. As early as 1921 the Sheppard-Towner Act tied funds for midwifery education to implementation of regulation, and thereby persuaded all but ten states to pass laws governing midwifery. For a discussion of the federal government's decision to tie funding to compliance with federal guidelines in public health, see generally James G. Hodge, *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 100 n.26 (1997).

The federal government influences midwifery through its role as a major employer of health care providers serving Native Americans, veterans, and the military; as a major purchaser of services; as the employer of thousands of federal employees; as the country's largest insurance carrier under Medicare and Medicaid; and, as the funder of education grants for nurse midwives. In addition, the federal Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461 (1994), exerts a profound and growing influence on healthcare providers by preempting state regulation of private health insurance for an increasingly large percentage of the country's managed care organizations. See *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (holding that ERISA creates an exclusively federal cause of action for most contract and tort claims, effectively preempting most state

prohibit or criminalize entry, into the profession through licensure and other mechanisms.<sup>40</sup> Entry requirements vary from state to state, affecting all nurse midwives and direct-entry midwives either directly or indirectly.<sup>41</sup>

Licensure is the most direct control over entry into the profession and hence, is of key importance.<sup>42</sup> The primary justification for licensure is

regulation of ERISA-covered plans). Thus, ERISA nullifies some state statutory protection afforded midwives and their clients. State protections include requiring health plans to allow women direct access to providers of obstetric and gynecologic services, mandating that these services be rendered by primary care providers, and designating nurse midwives as such providers. See *American College of Nurse-Midwives State and Federal Action on Primary Care and Direct Access to Obstetric and Gynecologic Providers*, FACT SHEET, available at <http://www.acnm.org/prof/display.cfm?id=90> (Feb. 2000). For a discussion of the impact of ERISA on state health care, see generally Jesselyn Alicia Brown, Note, *ERISA and State Health Care Reform: Roadblock or Scapegoat?*, 13 YALE L. & POL'Y REV. 339 (1995).

Medicaid, federal health insurance for the poor, exerts substantial influence by validating midwifery. Federal law requires coverage for nurse-midwifery services, 42 U.S.C. § 1102 (1994), and regulations mandate this coverage whether or not the nurse midwife is supervised by, or associated with, a physician 42 C.F.R. § 441.21 (2001), and regardless of the practice setting, whether in hospitals, homes, or clinics. Medicare Program: Nurse-Midwife Services, 60 Fed. Reg. 61,483, 61,485 (Nov. 30, 1995). These provisions provide a national standard and thereby encourage nonrestrictive policies for nurse midwives. Medicaid fee-for-service reimbursement rates and managed care policies determine the amounts midwives receive in payment for services to Medicaid or managed care clients, thereby affecting the financial viability of nurse-midwifery practice.

40. States' authority to regulate midwifery derives from the police power that enables states to protect the health, safety, and general welfare of the people. KENNETH R. WING, *THE LAW AND THE PUBLIC'S HEALTH* 19 (1985). Courts have allowed states to protect the public's health for two purposes, the protection of the health of an individual citizen and the protection of the health of society as a whole. *Id.* States use their police power to regulate and license health care professionals, including midwives. BARRY R. FURROW ET AL., *HEALTH LAW*, HORNBOOK SERIES 65-66 (1995). For a discussion of the relationship between a state's police power and the protection of public health, see generally Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations*, 8 ANNALS HEALTH L. 201 (1999) (summarizing the history of states' exercise of the police power to protect citizen health and trends in physician licensure in the United States from Colonial times).

Historically, states did not exercise this police power to regulate health practitioners. *Id.* at 206. During Colonial times, communicable diseases posed the greatest health threat. *Id.* at 203. Therefore, the states imposed quarantines and other restrictions on freedom of movement in an attempt to prevent epidemics of yellow fever, malaria or typhoid. *Id.* at 203-06.

As medical science advanced, the states began to regulate entry into the medical profession and the scope of medical practice. *Id.* at 209-11. These regulations reflected legislators' desire that health care professionals be qualified to practice. Prior to the 1860s, physicians did not necessarily provide more effective care than other healers. Therefore, regulation that required certain education or training was viewed as undesirable because it created a monopoly of certain classes of healers. With advances in immunization, anesthesia, and antisepsis in the 1800s, the predominant view of regulation began to change. *Id.* at 207-09. Shortly thereafter, the Supreme Court held that the physicians' integral role in insuring both the health of individuals and the public warranted intrusive regulation. *Id.* at 213 (citing *Hawker v. New York*, 170 U.S. 189 (1898)).

41. See *infra* notes 47-65 and accompanying text.

42. FURROW, *supra* note 40, at 65-55. Licensure statutes typically require that in order to practice

protection from unqualified, incompetent practitioners.<sup>43</sup> However, licensure of midwifery, as in all professions, also often serves an anticompetitive purpose.<sup>44</sup>

Licensure for midwives differ substantially among the states.<sup>45</sup> All states regulate nurse midwives,<sup>46</sup> but less than half statutorily regulate direct-entry midwives.<sup>47</sup> In the latter states, different governing bodies

a given health profession in the state, a person must be a graduate of an educational program meeting state requirements, must pass an examination, and must be of upright moral character. *Id.* at 58. This Note does not address other state regulations that also profoundly impact the practice of midwifery, including mandated relationships with physicians, mandated loci of childbirth, insurance regulation and reimbursement policies, and government-funded training grants.

43. Proponents of entry requirements claim that effective quality control, which impacts quality of care, depends on the expertise of the regulatory system rather than the presence of consumer choice in the market. FURROW, *supra* note 40, at 58. As a member of the Ohio Direct Entry Midwifery Council stated in a report to the Ohio legislature, licensure is a potential method by which the states can “assure competency [and] . . . protect the public from those who lack the knowledge, skills, and ability to be a safe practitioner.” Ohio Board of Nursing, *Position Statement: Direct Entry Midwife Study Council Report*, in DIRECT ENTRY MIDWIFERY STUDY COUNCIL: FINAL REPORT AND RECOMMENDATIONS (General Assembly of the State of Ohio, Jan. 15, 1998).

44. By filling the majority of seats on state licensing bodies, regulated professionals can raise barriers to entry into a profession, which may not necessarily be related to public health goals, having pronounced anticompetitive effects. FURROW, *supra* note 40, at 57. These barriers include discrimination against minorities, income support, and restriction of access to the profession. *Id.* Extensive literature exists reviewing the impact that occupational licensure in medicine and other professions has on protecting the public and in protecting the self-interest of the profession. See generally FURROW, *supra* note 40, at 57-58 (citing Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6 (1976); Reuben Kessel, *Price Discrimination in Medicine*, 1 J.L. & ECON. 20 (1959); Reuben Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267 (1970)).

45. See generally AM. COLL. NURSE-MIDWIVES, NURSE-MIDWIFERY TODAY: A HANDBOOK OF STATE LAWS & REGULATIONS 2000 (2000) [hereinafter HANDBOOK] (summarizing state laws and regulations regarding entry requirements, scope of midwifery practice, relationships with other professionals, application process, and related statutory provisions affecting nurse midwives); AM. COLL. NURSE-MIDWIVES, DIRECT ENTRY MIDWIFERY: A SUMMARY OF STATE LAWS AND REGULATIONS (1999) [hereinafter SUMMARY] (summarizing state laws and regulations or, if none, administrative or judicial decisions, affecting the practice of direct-entry midwives); AM. COLL. NURSE-MIDWIVES, FACT SHEET: STATE LAWS GOVERNING DIRECT ENTRY MIDWIFERY (2001) at <http://www.acnm.org/prof/display.cfm?id=93> [hereinafter FACT SHEET]; Midwives' Alliance of North America, Direct-Entry Midwifery State-by-State Legal Status, at <http://www.mana.org/statechart.html> (last modified Aug. 21, 2001) [hereinafter MANA] (listing and categorizing the legal status of direct-entry midwifery in each state).

46. HANDBOOK, *supra* note 45, at vii.

47. SUMMARY, *supra* note 45, at 11; FACT SHEET, *supra* note 45; MANA, *supra* note 45. See generally Suzanne Hope Suarez, *Midwifery is Not the Practice of Medicine*, 5 YALE J.L. & FEMINISM 315 (1993); Charles Wolfson, *Midwives and Home Birth: Social, Medical, and Legal Perspectives*, 37 HASTINGS L.J. 909 (1986) (discussing the legal status of direct-entry midwives, the problems attendant to legal ambiguity or illegality, and proposals for addressing these problems); Matt Kitz, Note, *Can Missouri Catch Up? Why Missouri Laws Work Unconstitutional Discrimination Against Lay Midwives and What Can Be Done to Stop It*, 67 UMKC L.R. 427 (1998).

usually license nurse midwives and direct-entry midwives.<sup>48</sup> Generally, physicians or nurses control the licensing body.<sup>49</sup>

### *I. Entry Requirements for Direct-Entry Midwives*

The number of states licensing direct-entry midwives, though small, continues to grow.<sup>50</sup> The mandated entry requirements vary substantially; however, seventeen states recognize NARM's Certified Professional Midwife certification in their regulations.<sup>51</sup> New Mexico, the state with the highest proportion of midwife-attended births,<sup>52</sup> provides one example of state licensing of direct-entry midwives.<sup>53</sup> The requirements include such basics as age and competency in adult and neonatal cardiopulmonary resuscitation.<sup>54</sup> Incorporating the NARM standards by inference, New Mexico requires at least one year of education and at least six months of an apprenticeship that includes twenty-five deliveries.<sup>55</sup>

48. For example, in Alaska the two regulatory bodies are the Board of Nursing and Board of Certified Direct-Entry Midwives while in California, the Board of Nursing and the Medical Board are the regulatory authorities. *See* ALASKA STAT. § 08.68 (Michie 2001) ALASKA STAT. § 08.65 (Michie 2001); CAL. BUS. & PROF. CODE §§ 2746 to 2746.8 (West 2001); CAL. BUS. & PROF. CODE §§ 2505 to 2521 (West 2001); In contrast, in New Mexico, the Department of Health licenses and regulates both nurse midwives and direct-entry midwives, but different rules and regulations apply to each group. N.H. ADMIN. CODE tit. 16, § 11.2 and 11.3.

49. Only Utah and New York have midwifery boards. HANDBOOK, *supra* note 45, at vii.

50. Between thirteen and seventeen states have licensure procedures for direct-entry midwives. *See* MANA, *supra* note 45; FACT SHEET, *supra* note 45. In contrast, in 1986 only five states had licensure legislation, four of which passed the legislation between 1981 and 1987. Irene H. Butter & Bonnie J. Kay, *State Laws and the Practice of Lay Midwifery*, 78 AM. J. PUB. HEALTH 1161, 1162-65 (1988).

51. These states include Alaska, Arizona, Arkansas, Colorado, Louisiana, Minnesota, New Hampshire, New Mexico, Oregon, South Carolina, Tennessee, Texas, and Vermont. California, Florida, Montana, and Washington not only recognize the Certified Professional Midwife certification, but also use the NARM certification exam in the licensure process. *See* MANA, *supra* note 45. For a description of a Certified Professional Midwife, see *supra* note 29 and accompanying text.

52. Nat'l Vital Statistics Div., U.S. Dep't Health & Human Serv., Attendant by Place of Delivery, Each State, 1998, Oct. 17, 2000 (unpublished data, on file with author).

53. N.M. ADMIN. CODE tit. 16, § 11.3 (2000) as authorized by N.M. STAT. ANN. § 9-7-6 (F) (Michie 1978) and N.M. STAT. ANN. § 24-1-21 (Michie 1978). The regulations recognize Certified Professional Midwives and require New Mexico licensure: "Certified Professional Midwife (CPM) means an independent practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM). A CPM may not practice in New Mexico unless she/he holds a New Mexico license to practice midwifery." N.M. ADMIN. CODE tit. 16, § 11.3.7.4 (2000).

54. N.M. ADMIN. CODE tit. 16, § 11.3.8.3 (2000).

55. N.M. ADMIN. CODE tit. 16, § 11.3.10 (2000). The prefatory paragraph to the education regulation states that "[t]he Division will use the Standards and Core Competencies for the Practice of Licensed Midwifery in New Mexico as a guideline in determining the acceptability of an applicants [sic] educational experience." *Id.*

New York provides a contrasting example. New York attempted to unify the professions of direct-entry and nurse midwifery. New York's direct-entry midwife requirements include a nursing degree or diploma, and education in a midwifery program leading to a baccalaureate or higher degree.<sup>56</sup> The Board of Professional Midwifery, not a board of medicine or nursing, implements the law.<sup>57</sup>

The majority of states do not license direct-entry midwives. Some states without licensure nevertheless recognize the legality of the practice through registration, certification, or documentation.<sup>58</sup> Other states, by expressly regulating only nurse-midwifery and not addressing direct-entry midwifery, leave the legal status of direct-entry midwives statutorily ambiguous.<sup>59</sup>

Several state legislatures have considered legislation to regulate direct-entry midwives but ultimately have not enacted the proposed laws. For example, in Missouri, where direct-entry midwifery is illegal, the legislature rejected midwifery bills annually for almost a decade.<sup>60</sup> In Ohio, a legislatively-mandated Direct Entry Midwifery Study Council produced a report and recommendations that did not lead to the drafting of legislation.<sup>61</sup> Minnesota convened three consecutive bodies to recommend legislation, held four years of hearings between 1991 and 1995, but did not pass legislation until 1999.<sup>62</sup>

Some states criminalize direct-entry midwifery, but do not always impose an absolute ban. States may exempt certain categories of midwives

56. N.Y. EDUC. LAW § 6955 (McKinney 2001). *See also* N.Y. COMP. CODES R. & REGS. tit. 8, § 52.20 (2000). Qualifications for nurse midwives and direct-entry midwives are not separated. *See id.*

57. N.Y. EDUC. LAW § 6954 (McKinney 2001). For a discussion of *Lange-Kessler v. Dep't. Educ.*, 109 F.3d 137 (2d Cir. 1997), upholding New York's midwifery law, see *supra* note 105 and accompanying text.

58. MANA identifies New Hampshire as certifying, Colorado as registering, and Texas as documenting. MANA, *supra* note 45.

59. MANA identifies Connecticut, Nebraska, Ohio, South Dakota, West Virginia, and Wisconsin in the category of not legally defined but not prohibited. MANA, *supra* note 45.

60. *See generally* Kitzi, *supra* note 47, at 434-35, 443. Note that in Missouri the legal status of direct-entry midwives is not ambiguous. Midwifery is unlawful. MO. ANN. STAT. § 334.010 (West 2001). *See also* State *ex rel.* Mo. State Bd. of Registration for the Healing Arts v. Southworth, 704 S.W.2d 219, 225 (Mo. 1986) (en banc) (declaring the phrases "practice of medicine" and "practice of midwifery" not unconstitutionally vague and holding that the statute prohibits the practice of midwifery but "permits isolated or occasional gratuitous acts of midwifery"). *Id.*

61. *See generally* DIRECT ENTRY MIDWIFERY STUDY COUNCIL, *supra* note 29 (presenting the state of the law in Ohio in 1997, position statements by interested organizations, and minority and majority recommendations); Telephone Interview with a representative of Ohio Senator Merle Grace Kearns, Columbus, Ohio (Nov. 14, 2000).

62. *See generally* MARY M. LAY, THE RHETORIC OF MIDWIFERY: GENDER, KNOWLEDGE, AND POWER 15 (2000).

from prosecution. Exempted midwives may be those who provide gratuitous services,<sup>63</sup> those practicing cultural traditions,<sup>64</sup> or those serving religious communities.<sup>65</sup>

## 2. *Entry Requirements for Nurse Midwives*

In contrast to direct-entry midwifery, the practice of nurse midwifery is legal in all states and entry requirements vary only slightly.<sup>66</sup> Generally, licensure requires that a person be a registered nurse with additional formal training in midwifery and does not permit alternative preparation, such as apprenticeship.<sup>67</sup> Forty-five states and the District of Columbia specify or mention national certification, most expressly naming the American College of Nurse Midwives, as a requirement for licensure as a nurse midwife.<sup>68</sup> Many states regulate nurse midwives as a subset of advanced practice nurse practitioners.<sup>69</sup> A growing number of states

63. For example, Arkansas exempts “uncompensated labor support attendants.” ARK. CODE ANN. § 17-85-105(2)(b) (Michie 2002).

64. “[I]f the person’s cultural traditions have included, for at least two generations, the attendance of lay midwives at births, and if the person has attended at least 10 births . . . , [the person] is excluded from registration under this section . . . .” ALASKA STAT. § 08.65.170 (Michie 2000).

65. Legislation introduced in Illinois on January 3, 2001, included an example of exemption for serving religious communities: “The rendering of services by a person if such attendance is in accordance with the person’s religious faith and is rendered to persons with a similar religious faith.” 5 ILL. COMP. STAT. 80/4.22 (2000).

66. *See generally* HANDBOOK, *supra* note 45.

67. California’s regulations provide an example. To qualify for certification as a nurse midwife, a person must “be licensed as a registered nurse” and “be a graduate of a Board approved program in nurse-midwifery.” CAL. CODE REGS. tit. 16, § 1460, 1460(a)(1)(A)-(B) (2000). Alternatively, a registered nurse certified as a nurse midwife by a national organization qualifies. *Id.* at § 1460(a)(2)(B).

Prior to February 2000, California recognized verified clinical competence as an alternative to the formal education requirements for certification: California offered six ways in which a registered nurse could qualify for state certification to practice nurse midwifery. The options, which were repealed in 2000, included a successful challenge to a Board-approved program with verification of clinical competence verified by a physician or certified nurse midwife, partial fulfillment of requirements through clinical training and practice with supplemental education in a Board-approved program, and partial fulfillment through clinical training and practice plus verification of competence. 16 CAL. CODE REGS. tit. 16 § 1460 (a)(2)(A)-(a)(2)(D)(2) (1981), *cited in* HANDBOOK, *supra* note 45, at CA 2.

68. The states that do not mention national certification are Kansas, New York, Oregon, Tennessee, and Wyoming. HANDBOOK, *supra* note 45, at viii. For a description of the American College of Nurse Midwives Certification Council and certification requirements, see *supra* note 30 and accompanying text.

69. Missouri’s regulations provide an example. “Registered professional nurses who are . . . certified nurse midwives . . . shall— (1) Hold current license to practice in Missouri as registered professional nurses; and (2) Be certified in their respective advance practice nursing clinical specialty area by a nationally recognized certifying body, . . . ; and (3) Submit documented evidence of satisfactory, active, up to-date certification . . . .” MO. CODE REGS. ANN. tit. 4, § 200-4.100(2) (2000).

require a masters degree, half of which now specifically require a masters in nursing.<sup>70</sup>

### C. *Judicial Decisions Controlling Entry into Midwifery*

#### 1. *Court Decisions That Legalize Direct-Entry Midwifery*

Court decisions decriminalize the practice of direct-entry midwives in some states. Ambiguity in statutes or restrictive legislation brings the legal status of direct-entry midwives to the attention of the courts.<sup>71</sup> Suits typically arise from criminal or civil actions brought by medical and nursing boards who allege that a midwife is practicing medicine, nursing, or nurse-midwifery without a license.<sup>72</sup> Midwives and their clients also sue medical and nursing boards hoping to overturn a highly restrictive statute or to clarify an ambiguity in the law.<sup>73</sup>

In Kansas and Tennessee, courts persuaded by the midwives' plain language arguments<sup>74</sup> exempted midwifery from acts regulating physicians or nurses and found that the practice of midwifery without a license is not illegal.<sup>75</sup>

70. Including Missouri, twenty-one states have legislation or regulations that require or will require masters degrees. HANDBOOK, *supra* note 45, at x. Of these, twelve states specify a masters in nursing. *Id.* These twelve states are Alabama, Hawaii, Maine, Mississippi, Missouri, Montana, North Dakota, Oklahoma, South Carolina, Tennessee, Texas, and Washington. *Id.* The other states requiring masters degrees are Arizona, Colorado, Georgia, Illinois, Louisiana, Nevada, Ohio, Oregon, and Wisconsin. *Id.*

The masters degree requirement has become increasingly popular. Alabama, North Dakota, and Ohio added this prerequisite between 1995 and 1997. Additionally, Hawaii, Illinois, Maine, Mississippi, and Nevada were added to the list between 1997 and 2000. In nine more states, legislation imposing a masters degree requirement for nurse-midwifery practice became effective after January 1, 2001. Alyson Reed, *Trends in State Laws and Regulations Affecting Nurse-Midwives: 1995-1997*, 42 J. NURSE-MIDWIFERY 421 (1997); HANDBOOK, *supra* note 45, at x.

71. See generally Noralyn O. Harlow, Annotation, *Midwifery: State Regulation*, 59 A.L.R. 4th 929 (1988) (providing an overview of state and federal cases relating to the practice of midwifery).

72. See, e.g., *People ex rel. Sherman v. Cryns*, No. 2-01-0952, 2001, 2002 Ill. App. LEXIS 61 (Ill. Ct. App. Jan. 28, 2002).

73. See, e.g., *Sammon v. New Jersey Bd. of Medical Examiners*, 66 F.3d 639 (3d Cir. 1995).

74. See *infra* notes 76-90 and accompanying text.

75. The Midwives' Alliance of North America lists twelve states where direct-entry midwifery is "legal by judicial interpretation or statutory inference." MANA, *supra* note 45. See, e.g., *State Bd. of Nursing v. Ruebke*, 913 P.2d 142 (Kan. 1996) (overruling an attorney general opinion establishing the practice of midwifery as a per se violation of the Kansas Healing Arts Act and determining that an individual who assists with birth assumes medical duties and so must hold a license); *Leggett v. Tenn. Bd. Nursing*, 612 S.W.2d 476, 481 (Tenn. Ct. App. 1980) (holding that the board of nursing did not have authority over nurse claiming to provide nurse midwife services). In *Leggett*, the Medical Practice Act exempted midwifery services and the Nurse Practice Act did not provide for nurse midwives. *Id.* at 480. The nursing statute restricted midwifery to nurses, but regulations forbade them from attending home births. *Id.* Therefore, preventing Leggett from practicing would be "contrary to

In *State Board of Nursing v. Ruebke*,<sup>76</sup> the Kansas Supreme Court held that midwifery is separate and distinct from medicine and nursing, is not incident to the practice of medicine and surgery, and does not come within the scope of either act.<sup>77</sup> In its reasoning, the court relied upon the history of Kansas's regulation of medicine, legislative history, and the specific language of the acts.<sup>78</sup>

In analyzing the plain language of Kansas's statutes, the *Ruebke* court determined that "[p]regnancy and childbirth are neither pathologies nor abnormalities" and thus do not constitute a "disease, ailment, deformity or injury" for purposes of the act.<sup>79</sup> The court further noted that Kansas law defines medicine and healing arts more narrowly than states such as Missouri<sup>80</sup> and California<sup>81</sup> where courts hold that midwifery constitutes the illegal practice of medicine.<sup>82</sup>

In *Leggett v. Tennessee Board of Nursing*,<sup>83</sup> the Tennessee Court of Appeals also found that direct-entry midwifery was not illegal, but based

the goal of promoting public health." *Id.* at 481. Note that Tennessee has since passed legislation regulating direct-entry midwives. TENN. CODE ANN. §§ 63-29-101 to 116 (Supp. 2001).

76. 913 P.2d 142 (Kan. 1996). In this case, the State Board of Health Arts and the State Board of Nursing sought to enjoin Ruebke, president of the Kansas Midwives Association, from continuing her practice. *Id.* at 147-48. The trial court's finding of facts did not support the Boards' allegations that she jeopardized the lives of mothers and babies in the case of three pregnancies. *Id.* at 147-49. The court did, however, find that Ruebke was an actively practicing "lay midwife comprehensively assisting pregnant women with prenatal care, delivery, and post-partum care." *Id.* at 148.

77. *Id.* The court reasoned that, because the action taken against Ruebke was a civil, not criminal, action, it should interpret the statute by reference to sound public policy. The ambiguity in the law required that the court construe the statute in a manner consistent with legislative intent and give commonly used words their ordinary meaning. *Id.* at 153-54. The court reasoned that the terms used in the healing arts statute, "ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity or injury" have "ordinary, definite, and ascertainable meaning." *Id.* at 154. The court similarly construed the nursing act, which defines nursing as caring for "persons who are experiencing changes in the normal health processes." *Id.* at 161.

78. *Id.* at 153-54. The court found that of the five acts passed by the Kansas legislature since 1870 that restrict the practice of medicine, none applied or was meant to apply to midwives. *Id.* at 150-51. The court quoted legislative history of the current law suggesting a specific intent to exclude midwifery. *Id.* at 152.

79. *Id.* at 154-55.

80. *Id.* See *State ex rel. Mo. State Bd. of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219 (Mo. 1986) (en banc). In *Southworth*, the Missouri Supreme Court held that the statute prohibiting the unlicensed practice of medicine was not unconstitutionally vague. *Id.* at 224. The statute provided no procedure for licensing midwives and stated that "[i]t shall be unlawful for any person not now a registered physician within the meaning of the law to . . . engage in the practice of midwifery." *Id.* at 222 (quoting MO. REV. STAT. § 334.010 (1978)). The court held that midwifery was a word "of common usage" and the statute was therefore not unconstitutionally vague. *Id.* at 223.

81. Ruebke, 913 P.2d at 155. See *Bowland v. Municipal Court for Santa Cruz County Judicial Dist.*, 556 P.2d 1081 (Cal. 1976). See *infra* notes 94-98 and accompanying text for an overview of *Bowland*.

82. See Ruebke, 913 P.2d at 155.

83. 612 S.W.2d 476 (Tenn. Ct. App. 1980).

its holding on a different rationale than that adopted by the *Ruebke* court.<sup>84</sup> Because lay midwifery was unregulated in Tennessee, the court held that the Board of Nursing lacked jurisdiction over a nurse practicing lay midwifery.<sup>85</sup> The court then made a public policy argument, noting that in case of an emergency complication during birth, a certified nurse midwife or a physician in a hospital would be better qualified to serve a mother and child than a lay midwife in a home.<sup>86</sup> However, many families choose to practice home birth.<sup>87</sup> Tennessee law governing certified nurse midwives forbade them to practice in a home setting.<sup>88</sup> Therefore, forbidding nurses from practicing lay midwifery would allow anyone except a licensed nurse to act as a midwife.<sup>89</sup> The court found this omission “contrary to the goal of promoting public health.”<sup>90</sup>

## 2. Court Decisions That Uphold Criminalization of Direct-Entry Midwifery and of Restrictive Entry Requirements

The *Ruebke* and *Leggett* decisions are exceptions to the general pattern that courts uphold statutes criminalizing or severely restricting direct-entry midwifery. Generally, courts analyzing these statutes do not find them unconstitutionally vague or overbroad,<sup>91</sup> and uphold their constitutionality against due process and privacy rights violation challenges.<sup>92</sup>

The United States Supreme Court’s recognition of the right to privacy

84. *Id.* at 481. *Leggett* was a registered nurse who provided midwifery services and had delivered approximately fifty babies. *Id.* at 477-78. The Tennessee Board of Nursing revoked her license on the grounds that she was practicing nurse midwifery without meeting Tennessee’s entry requirements for nurse midwives. *Id.* at 478. Specifically, *Leggett* was not a graduate of an approved nurse-midwifery program and had not been certified by the American College of Nurse Midwives. *Id.* at 478. Both *Leggett* and the Board agreed that midwifery was not regulated under Tennessee law. *Id.* at 479.

85. *Id.* at 480-81. The court noted that the Medical Practice Act exempted midwives and the Nursing Practice Act did not include midwives. *Id.* at 480. Therefore, lay midwifery was not illegal. *Id.* at 478, 480. Because the Board of Nursing derived its authority from its authorizing legislation, it could not have jurisdiction over midwifery. *Id.* at 479-80. If the Board of Nursing lacked jurisdiction, it could not discipline a licensed nurse for practicing midwifery. *Id.* at 480-81.

86. *Id.* at 481.

87. *Id.*

88. *Id.*

89. *Id.*

90. *Id.*

91. See, e.g., *Dickerson v. Stuart*, 877 F. Supp. 1556, 1563 (M.D. Fla. 1995) (holding that the Florida statute regulating direct-entry midwifery was not unconstitutionally vague and did not violate constitutional rights to freedom of religion and speech); *People v. Rosburg*, 805 P.2d 432, 439 (Colo. 1991) (holding that the Colorado statute prohibiting the practice of midwifery by anyone other than nurse midwives was not unconstitutionally vague).

92. For a discussion of due process and privacy rights violation challenges, see *supra* notes 93-105 and accompanying text. For another approach, see *Watson v. Ky. Bd. of Nursing*, 37 S.W.3d 788, 791-92 (Ky. Ct. App. 2000) (rejecting the claim that only the legislature may eliminate lay midwifery).

in a series of reproductive health cases led to challenges of restrictive statutes on the ground that reproductive freedom extends to childbirth.<sup>93</sup> *Bowland v. Municipal Court*,<sup>94</sup> filed just a few months after the *Roe v. Wade*<sup>95</sup> decision legalized abortion, is one of the first of such cases.<sup>96</sup> In *Bowland*, the court held that a woman's right to privacy does not allow her "the liberty to choose whomever she wants to assist in the delivery of her child."<sup>97</sup> The court reasoned that *Roe*'s recognition of the state's interest in the well-being of an unborn child in the third trimester of pregnancy allowed the states the power to limit a woman's right to privacy in childbirth.<sup>98</sup>

Courts continue to follow *Bowland*, which established that the right to privacy does not extend to choice of childbirth attendant. Twenty years later, in *Hunter v. State*,<sup>99</sup> a Maryland appellate court relied upon *Bowland* and its progeny<sup>100</sup> to reach the same conclusion: regulation of midwifery does not violate a woman's reproductive rights.<sup>101</sup>

93. For example, in *Bowland v. Municipal Court*, 556 P.2d 1081 (Cal. 1976), the court cited Supreme Court cases establishing a woman's right to privacy regarding contraception and abortion including, *inter alia*, *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453-54 (1972); *Griswold v. Connecticut* 381 U.S. 479, 485-86 (1965). 556 P.2d at 1089.

94. 556 P.2d 1081 (Cal. 1976).

95. 410 U.S. 113 (1973).

96. In *Bowland*, California brought criminal charges against three women for assisting a woman in pregnancy and childbirth without a license. 556 P.2d at 1082. The women challenged California's healing arts law. *Id.* at 1082. The court held that the healing arts law prohibited assistance of a woman during childbirth, was not unconstitutionally vague, and did not violate a woman's right to privacy. *Id.* at 1084. In holding that midwifery constituted the practice of medicine, the court cited numerous cases for the proposition that childbirth is "a normal a biological function of women rather than a disease or sickness." *Id.* Among the cases cited was *Commonwealth v. Porn*, 82 N.E. 31 (Mass. 1907). *Id.* For a summary of the facts of *Porn*, see *supra* notes 1-8 and accompanying text. However, the court also found that although pregnancy is a normal condition, pregnancy may "still be considered a sickness or affliction within the contemplation of [the statute]." *Bowland*, 556 P.2d at 1084.

97. *Bowland*, 556 P.2d at 1088-89.

98. *Id.* at 1089. The court noted that the legislature had not gone so far as to compel women to deliver their babies in a hospital or with the assistance of a physician. *Id.* This reasoning foreshadowed the case of Rebecca Corneau, a Massachusetts woman jailed for over a month to compel her to receive medical care during childbirth. See Brian MacQuarrie & Richard Higgins, *Attleboro Sect Member Gives Birth State Custody Seen; Court Hearing Is Set*, BOSTON GLOBE, Oct. 17, 2000, at B1, available at 2000 WL 3346479.

99. 676 A.2d 968, 976 (Md. Ct. Spec. App. 1996). In *Hunter*, Maryland charged a direct-entry midwife with practicing midwifery without the mandated certification as a nurse midwife. *Id.* at 969.

100. *Id.* at 976. *Hunter* cites, in addition to *Bowland*, *Leigh v. Board of Registration in Nursing*, 506 N.E. 2d 91 (Mass. 1987) (holding that midwifery does not interfere with fundamental rights); *People v. Rosburg*, 805 P.2d 432, 437 (Colo. 1991) (holding that the right to choose a lay midwife for assistance in childbirth is not encompassed within the right to privacy); *State v. Kimpel*, 665 So.2d 990, 994 (Ala. Ct. App. 1995) (dismissing as without merit the argument that the midwifery statute constitutes an unconstitutional violation of the right to privacy). *Id.*

101. 676 A.2d at 976. The court rejected the claim that the statute violated a woman's right to privacy, stating that "[o]ther States have addressed the specific issue in the case at bar and have

Courts have also rejected substantive due process claims that restrictive statutes prevent aspiring midwives from earning a living at their chosen profession. In the first federal appellate decision on the issue, the United State Court of Appeals for the Third Circuit, in *Sammon v. New Jersey Bd. of Medical Examiners*,<sup>102</sup> held that New Jersey's midwifery statute did not violate the due process rights of non-licensed midwives to practice midwifery.<sup>103</sup> Applying a rational basis test, the court found that the required formal training was not irrationally related to the state's interest in protecting the health of mothers and infants.<sup>104</sup> The court recognized that other requirements might be more effective in protecting these interests; however, the court declined to find the statute unconstitutional, stating, "[i]t is for the legislature, not the courts, to balance the advantages and disadvantages of the . . . requirement."<sup>105</sup>

### III. ANALYSIS

The current legal climate in the states, created by statutes, regulations, and judicial decisions affecting entry into the profession of midwifery, limits midwifery practice and hence limits its public health benefits.<sup>106</sup> The states that severely restrict entry into direct-entry midwifery as well as the states that have no entry requirements at all threaten the well-being of both midwives and their patients. Requiring nurse midwives to have educational credentials beyond those necessary for safe practice prevents otherwise qualified practitioners from entering the profession. When

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refused to extend a woman's right to privacy to include her choice of whomever she wishes to assist her during childbirth." *Id.*

102. 66 F.3d 639 (3d Cir. 1995). In this case, a direct-entry midwife and potential clients challenged the midwifery law's formal education requirements. *Id.* at 640-41.

103. *Id.* at 641.

104. *Id.* at 646.

105. *Id.* at 646 (citing *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 487 (1955)). See also *Lange-Kessler v. Dep't Educ.*, 109 F.3d 137 (2d Cir. 1997), in which the Second Circuit also used a rational basis test and concluded that New York's midwifery law did not violate midwives' due process rights to practice their profession. *Id.* at 141. The *Lange-Kessler* court also addressed the privacy issue, holding that a woman's right to privacy does not include the right to choose a birth attendant. *Id.* at 142. For a discussion of New York's midwifery law, see *supra* notes 56-57 and accompanying text.

106. Although state regulation exerts primary influence on the practice of midwifery, federal policy provides an important incentive for both midwives and for states. For example, federal financing and training provide some encouragement for nurse midwifery, though not direct-entry midwifery. Federal financing for midwifery is tied to state policy. If midwifery is prohibited or excessively restricted, the federal government does not reimburse midwives for care provided. Yet, the incentive of payment for midwifery services can make a difference. For a discussion of federal influence, see *supra* note 39.

midwives and their advocates have challenged these restrictions, the results have not been promising.

*A. Absent or Overly Restrictive Entry Requirements Jeopardize Direct-Entry Midwives and Their Patients.*

Entry requirements unrelated to the skills and knowledge necessary for midwifery practice harm both midwives and the public. Laws that criminalize or severely restrict direct-entry midwifery jeopardize both the midwives' livelihood and the health and well-being of their patients and the public. Outright prohibition, ostensibly to protect mothers, does not protect the health of the public. Women choosing home births may be at greater risk because the birth may be unattended.<sup>107</sup> Illegally practicing midwives may be subject to harassment that endangers their patients.<sup>108</sup> Justifiably fearing reprisal, these midwives may hesitate to refer women with complications to a hospital.<sup>109</sup> Furthermore, when midwifery is illegal, a person who continues to practice is open to harassment by any person with animus against her.<sup>110</sup>

Even states with less restrictive entry requirements often impose standards beyond those necessary for the safe and competent practice of direct-entry midwifery. New Mexico, which recognizes the NARM certification, exemplifies some of the shortcomings of current law.<sup>111</sup> New Mexico's one-year formal education requirement exceeds NARM recommendations and thus limits the advantages of the NARM process.<sup>112</sup>

107. The *Leggett* court specifically identified this danger. See *Leggett v. Tenn. Bd. Nursing*, 612 S.W.2d 476, 481 (Tenn. Ct. App. 1980).

108. The circumstances of a raid on a "well-established and openly-operated alternative birthing clinic" in Missouri illustrates one threat that illegality poses to the health and well-being of children and families. *Hummel-Jones v. Strobe*, 25 F.3d 647, 648-49 (8th Cir. 1994). A team of state and local officials raided the birthing clinic shortly after the birth of a baby and found the mother, father, and child alone. *Id.* at 649. The judge noted that "[t]he searchers stayed and kept the family on the couch until after 5 A.M., or for most of the night, ignoring any risk to Hummel-Jones's health due to the inevitable trauma of such an invasion only hours after delivery." *Id.* at 650.

109. One example of this kind of harassment and reprisal was related by a direct-entry midwife interviewed in Missouri. Newman, *supra* note 25, at 145. When one of the midwife's patients went into premature labor, the midwife decided to go to the hospital in case the baby needed medical assistance. *Id.* Because the woman's labor progressed on the way to the hospital, she was ready to give birth shortly after reaching the delivery room. *Id.* As the obstetrician approached the room, he asked the midwife who she was. *Id.* After she identified herself as the midwife, "he did a military about face, threw his hands in the air, and said, 'I'll have nothing to do with this.'" *Id.*

110. See, e.g., *Watson v. Ky. Bd. of Nursing*, 37 S.W.3d 788, 789 n.1 (Ky. Ct. App. 2000) (An ex-husband who was in a custody fight with his midwife ex-wife instigated this suit for practicing nursing without a license to harass his spouse.).

111. For New Mexico's statute, see *supra* notes 53-55 and accompanying text.

112. For the NARM certification process, see *supra* note 29 and accompanying text.

The New York law<sup>113</sup> accomplishes the important goal of uniting midwives under one midwifery board. However, the law excludes most direct-entry midwives who have been educated through apprenticeship and self-teaching and hence is disastrous for most direct-entry midwives.<sup>114</sup> For instance, within a year of the statute's enactment, New York authorities conducted an undercover investigation of Roberta Devers-Scott, a direct-entry midwife, arrested her, and charged her with the felony of practicing midwifery without a license.<sup>115</sup> The New York law exemplifies the observation of some commentators that, for direct-entry midwives and their clients, no law is better than some law.<sup>116</sup>

Current licensing standards represent only small steps towards enacting legislation that effectively protects the public from incompetence while still promoting the public health benefits of expanded midwifery practice.

*B. Masters Degree Requirements for Nurse Midwives Unnecessarily Limit the Benefits of Midwifery.*

Entry requirements for nurse midwives frequently exceed the qualifications necessary to fulfill the ostensible purpose of nurse-midwifery licensing, that is, assurance that women and infants have competent, qualified care. The number of states that have enacted legislation requiring a masters degree as an entry requirement to the practice of nurse midwifery increased by more than one hundred percent between 1995 and 2001.<sup>117</sup> Yet, almost a third of nurse midwives certified by the American College of Nurse Midwives Certification Council (ACC)

113. For a discussion of New York's law, see *supra* notes 56-57 and accompanying text.

114. The path to becoming a direct-entry midwife includes not only formal education mandated by the New York law, but also apprenticeship and self-teaching. For a description of direct-entry midwifery, see *supra* note 25 and accompanying text.

115. LAY, *supra* note 62, at 2. Citizens for Midwifery (CFM), the national advocacy organization for direct-entry midwives, reported that New York investigated most other direct-entry midwives. CFM reported that, as a result, most direct-entry midwives either ceased practicing or moved to other states. Telephone Interview with Susan Hodges, President, Citizens for Midwifery Board of Directors (Feb. 5, 2001).

116. See generally RAYMOND G. DEVRIES, MAKING MIDWIVES LEGAL: CHILDBIRTH, MEDICINE, AND THE LAW 47-87 (2d ed. 1996) (exploring the impact of legislation and regulation of lay midwifery in Texas, Arizona, and California); Irene H. Butter & Bonnie J. Kay, *State Laws and the Practice of Lay Midwifery*, 78 AM. J. PUB. HEALTH 1161 (1988) (summarizing the legal status of lay midwifery in 1987).

117. See HANDBOOK, *supra* note 45, at x. Many of these states require not only a masters degree, but a masters of science in nursing. *Id.* However, many CNMs with masters degrees have earned those degrees in disciplines more suited to the individual midwife's area of practice, such as public health or midwifery. Reed, *State Mandated Masters Degrees*, *supra* note 30. For a discussion of educational entry requirements for nurse midwifery licensure, see *supra* notes 66-70 and accompanying text.

had not earned masters degrees.<sup>118</sup> Analysis of ACC examination results do not suggest that those with masters degrees have improved performance or knowledge in the areas necessary for safe and competent midwifery practice.<sup>119</sup> These increased educational requirements, particularly those that recognize only a masters degree in nursing, seem to serve the second, less laudatory goal of professional licensure: anticompetitive protection of a profession.

Increased academic standards for nurse midwives has another negative effect. Midwifery benefits result from adherence to the midwifery model of care, a model that looks outside and beyond the medical model to provide care that is different in quality from obstetrical care.<sup>120</sup> A masters degree in nursing focuses on academic and intellectual abilities and prepares professionals for roles in administration and research.<sup>121</sup> These abilities and functions are important in society and within the health care profession. Nevertheless, they may not significantly improve the quality of direct care to an individual pregnant woman and her child. The midwifery model of care, in many ways, contrasts with the medical model of care. The more time a midwife-in-training spends within the high-tech academic medical center environment, the more engrained the values and practices of that environment may become.<sup>122</sup>

*C. Court Challenges to Prohibition of Direct-Entry Midwifery and to Restrictive Entry Regulation Are Not Promising Avenues for Improving Access to Midwifery.*

State and federal court decisions, which generally limit midwives' ability to enter the profession, disappoint those who seek to improve the well-being of women and children through expanded practice of direct-entry midwifery. The outcome of some of the favorable cases depended primarily upon unique circumstances within the state where the case was

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118. See Reed, *State Mandated Masters Degrees*, *supra* note 30.

119. See *id.* For a discussion of masters degrees and national certification, see *supra* note 69 and accompanying text.

120. For a description of the midwifery model of care, see *supra* notes 20-23 and accompanying text.

121. See Reed, *State Mandated Masters Degrees*, *supra* note 30.

122. Telephone Interview with Karen S. Fennell, R.N., M.S., Senior Policy Analyst, American College of Nurse-Midwives (Nov. 21, 2000); Interview with Sister Jeanne Meurer, CNM, MSN, FACNM, Co-Director, Woman's Place, Maplewood, Mo., former Director of St. Louis University Graduate Program in Nurse Midwifery and former Director of Nurse Midwifery, Department of Health and Hospitals, St. Louis, Mo. (Oct. 14, 2001) (note that neither of these midwifery programs survive today).

brought. *Ruebke*, for example, does not set persuasive precedent for overturning state anti-midwifery statutes because the court relied heavily on an in-depth analysis of the history of midwifery in Kansas.<sup>123</sup> A comparison of the Kansas definition of medicine considered in *Ruebke* and the California definition considered in *Bowland*, suggests that courts' can differ in their interpretation of the meaning of the term "medicine." Although the statutes are not entirely dissimilar, the courts reached opposite conclusions. *Leggett* was decided in a state that explicitly banned nurse midwives from attending homebirths,<sup>124</sup> a rule that allowed the court to base its decision on health policy. Other courts have identified similar contradictions yet upheld the statutes.<sup>125</sup>

## VI. PROPOSAL

To realize the public health promise of midwifery, state law should impose appropriate entry requirements for both direct-entry midwives and nurse midwifery under a single but bifurcated process. Although changes at the federal level can also be influential, they are marginally useful where state law creates a legally hostile environment.<sup>126</sup> Similarly, efforts aimed at making policy changes through court challenges of state law have proven generally ineffective.<sup>127</sup> Therefore, state laws regulating entry into the midwifery profession should acknowledge and accommodate the uniqueness of both direct-entry midwives and nurse midwives and also recognize that some midwives will continue to practice regardless of whether midwifery is legal. To protect its citizens, states should exempt specific categories of cultural, religious, and family attendants at childbirth.<sup>128</sup>

Adopting a unified but bifurcated process will acknowledge that neither complete unity between the two branches of midwifery nor

123. *See* State Bd. of Nursing v. *Ruebke*, 913 P.2d 142, 155 (Kan. 1996). *See also supra* notes 76-82 and accompanying text.

124. *See* *Leggett v. Tenn. Bd. Nursing*, 612 S.W.2d 476, 481 (Tenn. Ct. App. 1980).

125. *See, e.g.,* *Watson v. Ky. Bd. of Nursing*, 37 S.W.3d 788 (Ky. Ct. App. 2000).

126. While progress towards favorable entry requirements continues at the state level, the federal government can influence the use of midwives to improve the health of women and infants. Federal health care financing and regulatory policies should be evaluated for their potential for increasing utilization of midwives. The federal government should add appropriate financial and regulatory support of direct-entry midwifery. For a partial listing of the many mechanisms by which the federal government affects, and thus can promote, midwifery, see *supra* note 39.

127. For a discussion of court decisions affecting midwifery, see *supra* notes 91-105 and accompanying text.

128. For examples of state statutes and regulations that include such exemptions, see *supra* notes 63-65 and accompanying text.

complete unity of entry requirements is appropriate.<sup>129</sup> Direct-entry midwives and nurse midwives differ greatly: the scopes of practice are different; the locations of birthing practice are ordinarily different; the necessity for knowledge of pharmaceuticals is different; and the philosophies are different.<sup>130</sup>

Entry requirements for direct-entry midwifery can both protect the public and accommodate the unique skills and knowledge of direct-entry midwives. Legalization and effective regulation of direct-entry midwives remains highly controversial and difficult to implement, as the experiences of Missouri, Ohio, and Minnesota illustrate.<sup>131</sup> Direct-entry midwives enter the profession by apprenticeship and self-teaching as well as through formal education.<sup>132</sup> Entry requirements that rely exclusively upon formal educational achievement are inappropriate and might drive apprentice-trained direct-entry midwives underground. This result would be dangerous.<sup>133</sup> In contrast, entry requirements that include an assessment of skills and knowledge, rather than an examination of the method by which an applicant acquires them, offer greater public benefit by allowing greater numbers of qualified direct-entry midwives to enter the profession. The Certified Professional Midwife (CPM), the national certification program of the North American Registry of Midwives, provides such a process.<sup>134</sup> Currently, a number of states recognize CPM, but do not necessarily recognize CPM certification as a substitute for meeting the state's entry requirements.<sup>135</sup> However, most of the statutes licensing direct-entry midwives were passed before either the CPM certification mechanism or the competing direct-entry midwife certification process of the American College of Nurse Midwives was in place.<sup>136</sup>

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129. For a discussion of New York's unification of entry requirements and the resulting problems, see *supra* notes 55-57 and accompanying text.

130. These differences largely stem from direct-entry midwifery's focus on maternity care in the home setting and the broader focus of nurse midwives that includes well-woman and contraceptive care. See *supra* notes 25-28 and accompanying text for a summary of the similarities and differences between direct-entry midwifery and nurse midwifery. See *supra* note 31 and accompanying text for the perspective of a national leader of nurse midwifery on the relationship between nurse midwifery and direct-entry midwifery.

131. For a summary of these states' experiences in attempting to introduce and pass legislation regulating direct-entry midwives, see *supra* notes 60-62 and accompanying text.

132. For a description of the typical preparation of direct-entry midwives, see *supra* note 25.

133. For a discussion of potential problems resulting when direct-entry midwifery is illegal or when regulatory schemes for direct-entry midwives exclude significant numbers of practicing midwives, see *supra* notes 107-10 and accompanying text.

134. For a description of the CPM process, see *supra* note 29 and accompanying text.

135. For a list of the seventeen states recognizing CPM certification, see *supra* note 51.

136. See DOWER, *supra* note 10, at 7.

In most states, entry requirements for nurse midwives include recognition of ACC's Certified Nurse Midwife process. However, despite ACNM's opposition, many states have legislated entry requirements that exceed CNM standards, frequently requiring masters degrees.<sup>137</sup> Requirements greater than those stipulated by ACNM are counterproductive to the expansion of the number of midwife-attended births.

The ideal legislation regulating entry into the midwifery profession would incorporate both CPM certification for direct-entry midwives and CNM certification for nurse midwives. This entry regulation would foster parallel and coordinated regulation of direct-entry midwifery and nurse midwifery within a state.<sup>138</sup>

A unified board of midwifery should govern this dual-track regulatory process. An equal number of Certified Professional Midwives and Certified Nurse Midwives should sit on the unified board in order to prevent dominance by one branch over the other. Under this regulatory system, physicians and non-midwife nurses would no longer control entry into the midwifery profession.

Legislation introduced in Massachusetts provides one model for uniting the two branches.<sup>139</sup> The bill proposes creating a regulatory body, the Board of Registration in Midwifery.<sup>140</sup> The Board would consist of three midwives certified by the American College of Nurse-Midwifery Certification Council (ACC), three midwives certified by the North American Registry of Midwives (NARM), and three midwifery patients.<sup>141</sup>

137. For a discussion of the problems with masters degrees, see *supra* notes 70 and 117-22 and accompanying text.

138. Judith Rooks, a national nurse midwife leader, presents several models for the future of two branches of midwifery, proposing that the most productive model is "parallel paths with mutual collaboration and support." Rooks, *supra* note 31, at 319.

139. S. 569, 182d General Court, Reg. Sess. (Mass. 2001). Introduced in January 2001, the legislation was under consideration by the House-Senate Joint Health Care Committee in February and October 2002. Interview with James Henderson, President, Massachusetts Friends of Midwives, Feb. 27, 2002. Joint Committee on Health Care, List of Matters that Have Been Referred to the Committee at <http://www.state.ma.us/legis/comm/j24.htm> (last visited Oct. 2, 2002).

140. S. 569, 182d General Court, Reg. Sess. § 198(a) (Mass. 2001).

141. Massachusetts Senate Bill 569 § 198 reads as follows:

Section 198. Board of Registration in Midwifery.

- (a) The Board of Registration in Midwifery is created and shall consist of nine members, all of whom shall be residents of the commonwealth.
- (b) Subject to subsection (c) below, the members of the Board shall include the following:
  - (i) Three members of the Board shall be Certified Midwives or Certified Nurse Midwives.
  - (ii) Three members of the Board shall be Certified Professional Midwives.
  - (iii) Three members of the Board shall be persons who have never been a midwife and who have

Thus, unlike most state bodies governing midwives, physicians or nurses who are not midwives would not control entry into the profession.<sup>142</sup> Registration would require certification by either NARM or ACC.<sup>143</sup> The state would require no additional higher education, unlike many other states that require masters degrees.<sup>144</sup>

This model addresses many problems plaguing the current midwifery regulatory system. It takes advantage of the past two decades of work by hundreds of midwives and other public health professionals in addressing the health care needs of women and children. This model also builds on political advances. Although there are substantial similarities between the nurse midwives and direct-entry midwives, the differences between the two branches are real and will continue to conflict.<sup>145</sup> Continued

no financial interest in the practice of midwifery or in any health care facility, agency or insurer, two of whom must be either (A) a parent with at least one child born with the assistance of a person who practices or has practiced midwifery, or (B) a person who has engaged a provider who practices or has practiced midwifery for other services within the practice of midwifery.

(c) Eight years following the initial appointment of members of the Board, the Board shall establish by rule the requisite qualifications for the members of the Board who are registered midwives, which qualifications need not coincide with the terms of subsections (b)(i) and (ii) above. Upon the adoption of such rules, subsections (b)(i) and (ii) above shall be repealed.

(d) The Board members shall serve staggered 4-year terms as determined by rule.

(e) Members of the Board shall serve without pay. The Board members shall be entitled to reimbursement for per diem and travel expenses.

S. 569, 182d General Court, Reg. Sess. § 198 (Mass. 2001).

142. See *supra* note 49.

143. S. 569, 182d General Court, Reg. Sess. § 201 (Mass. 2001). Note that the bill recognizes both the ACC and NARM national certification of direct-entry midwives:

Section 201. Registration. Upon payment of the required registration fee, the Board shall register an applicant to practice midwifery who furnishes proof that said applicant is of good moral character and has successfully fulfilled the requirements of, and successfully completed the examination provided by:

(a) the ACNM Certification Council or the American College of Nurse-Midwives, or their successor organization, in the case of Certified Midwives and Certified Nurse Midwives; or

(b) the North American Registry of Midwives, or its successor organization, in the case of Certified Professional Midwives. A registered midwife shall practice within the standards and scope of practice established by the above-referenced organization that certified such registered midwife.

For a period of five years following the effective date of this bill, the Board shall have the authority and discretion to register applicants who have practiced midwifery prior to the effective date of this bill and have applied to the North American Registry of Midwives or the ACNM Certification Council for certification. Such registration shall terminate automatically two years following the date of registration unless the applicant has, by such time, successfully completed the examination provided by the North American Registry of Midwives or the ACNM Certification Council.

144. For a discussion of mandated masters degrees for nurse midwives, see *supra* notes 66-70 and accompanying text.

145. Note that the Massachusetts legislation is the product of a broad-based statewide coalition of

divisiveness will only limit the practice of midwifery and deny public health benefits to the community.

#### V. CONCLUSION

Midwives save lives. Yet overly-restrictive licensing requirements, as well as other legal obstacles, prevent qualified nurse midwives and direct entry midwives from practicing. Therefore, both individuals and society lose the substantial benefits that the expanded practice of midwifery could provide. While judicial approaches to overcoming legal barriers have been largely ineffective, state statutory changes hold great potential. This Note highlights some of the most helpful existing and proposed state licensing laws and suggests a model for duplication in other states. The proposed licensing changes would reduce one important class of barriers to midwifery practice. To fully achieve the promise of midwifery, social, political, and economic changes in the delivery of health care to women and infants must continue simultaneously.

*Susan Corcoran\**

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nurse midwives, direct-entry midwives, consumer organizations, and at large members. *See* Massachusetts Coalition for Midwifery, Members, at <http://home.attbi.com/~pumpkin.kids/MCM> (last visited Feb. 27, 2002).

\* B.A. (1972), Swarthmore College; M.P.H. (1978), University of North Carolina School of Public Health; J.D. (2002), Washington University School of Law. I would like to gratefully acknowledge the love and support of my husband and children, Josh, Jesse, and Milla Sanes, and to honor the beleaguered people of Gbecohn, Liberia, who first introduced me to midwifery.







