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THE MIDWIFE AND THE FORCEPS:
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The first thing which I can record concerning myself is, that I was born. These are wonderful words. This life, to which neither time nor eternity can bring diminution this everlasting soul, began.

My mind loses itself in these depths.

–Groucho Marx¹

People have told me it would probably be easier to do a drug deal in Missouri than to find a midwife.

–Dr. Elizabeth Allemann²

I. INTRODUCTION

On the morning of February 7, 2007, Senator Judy Lee stood before the North Dakota Senate Human Services Committee and introduced Senate Bill 2377, officially ushering the state into its first foray with the legal status of lay midwives.³ The bill was introduced out of a concern over the unregulated status of lay midwives in North Dakota and the desire of the Legislature to require some form of training for individuals who wished to assist in home births.⁴ By the time Senate Bill 2377 passed to the House of Representatives, it had been amended to direct the Legislative Council to conduct an interim study on whether current state law properly addressed obstetrical services performed by lay midwives.⁵

1. Quoteland.com, http://www.quoteland.com/author.asp?AUTHOR_ID=1785 (last visited Jan. 14, 2007).

2. Liz Heitzman, *Midwife Ban Leaves Family Scrambling*, COLUMBIA DAILY TRIB. (Mo.), Mar. 1, 2007, at A12.

3. *Hearing on S. 2377 Before the S. Comm. on Human Servs.*, 2007 Leg., 60th Sess. 1 (N.D. 2007) [hereinafter Senate Committee Hearings]. A “lay midwife” is one who does not have a nursing degree, but acquires experience solely through practice and apprenticeship. RAYMOND G. DEVRIES, *REGULATING BIRTH: MIDWIVES, MEDICINE, & THE LAW* 17 (1985).

4. Senate Committee Hearings, *supra* note 3, at 1 (statement of Sen. Judy Lee, Chairwoman, S. Comm. on Human Serv.).

5. Engrossed S. 2377, 2007 Leg., 60th Sess. (N.D. 2007). Interim studies are processes whereby the Legislative Council appoints a committee to research a particular issue for possible future legislation. North Dakota Legislative Council Interim Study Procedure.

Both the Senate and House Human Services Committees heard impassioned testimony from both sides of the issue.⁶ Representatives from the medical community argued that those who hold “themselves out as someone who can provide medical services” must meet a standard of competency and perform under a standard of care.⁷ Conversely, opponents of the bill stated that “there are going to be a lot of people like ourselves that are going to birth at home, no matter what the law says.”⁸ In the end, the House Human Services Committee unanimously recommended a Do Not Pass on the bill, believing that any study would inevitably result in unnecessary regulations.⁹ The House followed its recommendation, voting ninety to three to oppose the further study of lay midwives and the laws regulating them.¹⁰

With the Legislature opting against regulation or study, North Dakota remains among a significant minority of states with no official laws regulating (or prohibiting) lay midwives, allowing them instead to practice only by judicial or statutory interpretation.¹¹ However, with no laws on the books, these states unintentionally promulgate a wealth of potential problems, as there are no regulations or licensing standards to ensure the competency of midwives.¹² Additionally, the vague legal climate actually exposes midwives to the threat of being charged with unlawfully practicing medicine.¹³ By regulating midwives through sensible, relatively non-burdensome licensing requirements, North Dakota could simultaneously ensure the continued safety of its mothers and newborn citizens, the ability of

<http://www.legis.nd.gov/council/general/interim.html> (last visited Jan. 14, 2007). The committee reports its findings to the full Legislative Council prior to the next legislative session. *Id.* The council then drafts the committee’s recommendations into a bill or resolution, and presents them to the Legislative Assembly. *Id.*

6. Senate Committee Hearings, *supra* note 3, at 1-8; *Hearing on S. 2377 Before the H. Comm. on Human Servs.*, 2007 Leg., 60th Sess. 1-14 (N.D. 2007) [hereinafter House Committee Hearings].

7. Senate Committee Hearings, *supra* note 3, at 1-2 (statement of Bruce Levi, North Dakota Medical Association).

8. House Committee Hearings, *supra* note 6, at 8 (statement of Julie Liffbrig).

9. *See id.* at 1 (statement of Rep. Chuck Damschen) (“I think the study will end up in regulation. Childbirth has been around as long or longer than medicine.”).

10. *H. Journal*, 2007 Leg., 60th Sess. at 1147 (2007), available at <http://www.legis.nd.gov/assembly/60-2007/journals/hr57.pdf#Page1147>.

11. Laura D. Hermer, *Midwifery: Strategies on the Road to Universal Legislation*, 13 HEALTH MATRIX 325, 355 (2003). For a list of the other states which neither regulate nor prohibit lay midwifery, *see infra* notes 104-05 and accompanying text.

12. *See Hermer, supra* note 11, at 355 (“Such states give [midwives] legal sanction to practice, but do not otherwise regulate them.”).

13. *Id.*

women to choose home births, and the right of midwives to assist in the birthing process.¹⁴

The debate over midwifery has now been a source of controversy and bad feelings between opponents and proponents of the practice for over 100 years, and it has not aged well.¹⁵ It has become representative of a kind of meta-medical Battle of the Bulge, where midwives and the medical community have declared open war over the right to assist in childbirth, and there has been no cease fire in sight.¹⁶ However, unlike traditional concepts of war, here the battlefields are the American courtrooms, where midwives have both been prosecuted for circumventing state statutes or practicing medicine without a license, and have levied their own challenges against allegedly restrictive legislation.¹⁷ Meanwhile, mothers throughout the country wait nervously in the wings, concerned that attacks on lay midwives are synonymous with attacks on home births, and national organizations tentatively pick sides in the dispute.¹⁸

North Dakota resides as only a microcosm of the larger debate over midwifery; North Dakota is one of seven states in which midwives deliver less than four percent of births.¹⁹ However, the recent legislative session

14. See discussion *infra* Part IV.B (proposing specific provisions which take into consideration both safety concerns and the interests of midwives and their supporters).

15. See generally Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 64-67 (2004) (discussing the historical friction between midwifery supporters and the medical community).

16. See Adam Liptak, *Prosecution of Midwife Casts Light on Home Births*, N.Y. TIMES, Apr. 3, 2006, at A12 ("[Midwives] say the ability of women to choose to give birth at home is under assault from a medical establishment dominated by men who, for reasons of money and status, resent a centuries-old tradition that long ago anticipated the concerns of modern feminism."); see also Hermer, *supra* note 11, at 336 ("The midwife is a relic of barbarism. In civilized countries, the midwife is wrong, has always been wrong. . . . All admit that the midwife is wrong: It has been proven time and time again that it is impossible to make her right." (quoting Dr. Joseph B. DeLee, *Progress Toward Ideal Obstetrics*, 6 TRANSACTIONS AM. ASS'N FOR THE STUDY AND PREVENTION OF INFANT MORTALITY 6, 114-23 (1915))).

17. See Susan Corcoran, *To Become a Midwife: Reducing Legal Barriers to Entry Into the Midwifery Profession*, 80 WASH. U. L.Q. 649, 661 (2002) (noting that suits arise from criminal or civil actions against midwives for practicing medicine, nursing, or nurse-midwifery without a license, and also from midwives suing medical and nursing boards to overturn highly restrictive statutes or to clarify ambiguities in the law).

18. See Senate Committee Hearings, *supra* note 3, at 4 (testimony of Becky Olsen ("I urge you to vote against this proposed bill and allow parents to continue having the right to home births."); 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. 1416, 1416 (2005), available at http://www.bmj.com/cgi/reprint_abr/330/7505/1416 (noting that, while organizations like the American Public Health Association have adopted policies promoting or acknowledging the viability of home births, many organizations, such as the American College of Obstetricians and Gynecologists, oppose the practice).

19. Ed Brock, *Oh Baby! Popularity of Midwives Rises in State*, HENRY DAILY HERALD (Ga.), Feb. 17, 2006, available at http://www.henryherald.com/cnhi/henrydailyherald/features/local_story_048201219.html. The other six states are Alabama, Mississippi, Arkansas, Missouri,

has shown just how combustible the topic of midwifery is in the state and how vociferous its supporters and opponents are on the topics of choice and safety, respectively.²⁰ Furthermore, midwifery has seen a resurgence in recent years, which has sparked a related boom in midwifery prosecutions and statutory challenges.²¹ With its newfound sea legs, the issue of midwifery in North Dakota is all but certain to rear its head once again.²²

In the context of this background, this note illustrates the many facets of the midwifery debate and what options North Dakota may have when it comes time to construct reasonable midwifery legislation. More specifically, Part II discusses the history of midwives in America, including the long-running feud between midwives and physicians, and the differences between lay and nurse-midwives.²³ Part III explores the legal status of midwifery, including the statutory constructions of various states, the prosecutions of midwives, and the constitutional challenges which have risen over the years.²⁴ Part IV analyzes North Dakota's recent attempt at regulation with Senate Bill 2377 and provides guideposts for constructing future legislation that can protect the health and safety of North Dakota's mothers and children, and still remain fair to any lay midwives practicing within the state.²⁵ Finally, this note concludes that, while regulating midwifery is both a probable and desirable outcome in North Dakota, any such regulations need not affect the ability of midwives to practice in the state, nor prevent any woman from choosing how—and where—to bring her children into the world.

Kansas, and Louisiana. *Id.* Midwifery is most popular in Georgia, Alaska, New Hampshire, New Mexico, Oregon, and Vermont, where midwives attend over sixteen percent of births. *Id.*

20. See generally Senate Committee Hearings, *supra* note 3, at 1-8, and House Committee Hearings, *supra* note 6, at 1-14 (indicating that nine people testified in favor of the bill, and seventeen testified in opposition).

21. See A. Frank Adams III et al., *Occupational Licensing of a Credence Good: The Regulation of Midwifery*, 69 S. ECON. J. 659, 659 (2003) (noting that between 1975 and 1995, the amount of midwife-attended births rose from .09% to 5.95% of all births); see also Charles Wolfson, *Midwives and Home Birth: Social, Medical and Legal Perspectives*, 37 HASTINGS L.J. 909, 930 (1986) (noting that over twenty years ago, no laws of general application had been imposed on midwifery, so their constitutionality had yet to be tested).

22. See Corcoran, *supra* note 17, at 659 (discussing states like Missouri and Minnesota where, once initial attempts at regulation are made, the issue boomerangs through every session until legislation is finally passed).

23. See discussion *infra* Part II (discussing the history of midwifery and the distinctions between midwives).

24. See discussion *infra* Part III (focusing on midwifery law in the United States).

25. See discussion *infra* Part IV (discussing the legal status of midwives in North Dakota).

II. MIDWIFERY THROUGH A HISTORICAL LENS

While the general scope of the current midwifery debate focuses on the legal status of the profession, the conflict cannot be separated from basic principles of midwifery and the historical feud between midwives and medical professionals.²⁶ Such a broad analysis must begin with an understanding of the different forms of midwives.²⁷ Of equal importance is to appreciate how the philosophies of midwives differ from those of physicians, and how they have led to the current call for midwifery regulations.²⁸

A. THE TYPES OF MODERN MIDWIVES

Any analysis of midwifery regulation must intrinsically begin with a basic differentiation between the two types of modern midwives: certified “nurse-midwives” and lay—or direct-entry—midwives.²⁹ While both types of midwives focus on the concept of normal and natural childbirth, they differ when it comes to the philosophy, tradition, and the scope of their practice.³⁰ Furthermore, states generally distinguish between the two forms of midwives, resulting in very different legal results.³¹

Before nurse-midwives may attend deliveries, they must acquire nursing degrees and complete studies in standard gynecology and obstetrics.³² As registered nurses, these midwives usually obtain accreditation at a master’s level and have passed a national certification examination, giving them “the highest degree of traditionally accepted medical training” of practicing midwives.³³ However, nurse-midwives also come under scrutiny for straying from the natural approach to childbirth because of their ties to the medical community.³⁴ Since almost all of their work is done in a hospital setting under physician supervision, nurse-midwives often “capitulate to the wishes of obstetricians and other childbirth practitioners.”³⁵ Consequently, they generally adhere to established medical procedures and

26. See Hermer, *supra* note 11, at 329 (noting that, to understand the present debate over midwifery, it is important to understand the basic concepts of the profession).

27. See discussion *infra* Part II.A (comparing and contrasting lay and nurse-midwives).

28. See discussion *infra* Part II.B (discussing the different approaches of midwives and physicians, and the statistical analyses which have led to regulations on the midwifery profession).

29. Tovino, *supra* note 15, at 68.

30. Corcoran, *supra* note 17, at 654.

31. Tovino, *supra* note 15, at 68.

32. *Id.* at 69.

33. Hermer, *supra* note 11, at 333. See Corcoran, *supra* note 17, at 653-54 (noting that nurse-midwives are certified by the American College of Nurse-Midwives).

34. Hermer, *supra* note 11, at 334.

35. *Id.* at 326.

supervision.³⁶ As it stands, a properly licensed nurse-midwife may practice legally everywhere in the United States.³⁷

Lay midwives, on the other hand, are more commonly associated with “more natural and less intervention-oriented” home births.³⁸ These midwives generally do not have nursing degrees, but have acquired experience through practice and apprenticeship.³⁹ While some lay midwives become licensed if their home state requires it, others practice illegally, either by not meeting the codified requirements or by practicing in a state that does not legally recognize the profession.⁴⁰ Lay midwives who attain certification do so through the North American Registry of Midwives (NARM), an offshoot of the Midwives Alliance of North America (MANA).⁴¹ According to MANA, there are approximately 3,000 midwives in the United States without any formal training, roughly one-third of whom have been certified by NARM.⁴²

Even with the two factions of midwives focusing on natural childbirth, physician-assisted births remain the norm throughout the country.⁴³ However, this has not always been the case, as midwives previously dominated the birthing industry in the United States.⁴⁴ Between these two points in time was the spark of a power struggle between midwives and physicians, which has led to a historical conflict that has defined the birthing care system today.⁴⁵

B. A PEOPLE’S HISTORY OF MIDWIFERY AND THE PHYSICIAN-MIDWIFE CONFLICT

While midwifery may not qualify as the “world’s oldest profession,” it may well be the oldest “health profession” in history.⁴⁶ In a sense, the

36. *Id.* at 333.

37. *Id.*

38. *Id.* at 327. In fact, many argue that nurse-midwives and physicians, who are trained to deliver babies in hospitals, would make worse home birth attendants than lay midwives. JUDY BARRETT LITOFF, *AMERICAN MIDWIVES* 143-44 (1978) (quoting LESTER DESSEZ HAZELL, *COMMONSENSE CHILDBIRTH* 145 (1976)). Since what is normal in a hospital may be abnormal in a home setting, nurse-midwives and physicians would have the potential to provide inappropriate care to patients who choose home births. *Id.* Hospital trained individuals can cause problems by trying to “force what is happening in the mold of what they know.” *Id.* at 144.

39. DEVRIES, *supra* note 3, at 17.

40. Hermer, *supra* note 11, at 327.

41. Corcoran, *supra* note 17, at 653, 653 n.29.

42. Liptak, *supra* note 16, at A12.

43. Hermer, *supra* note 11, at 328.

44. BRIAN E. BURTCH, *TRIALS OF LABOUR: THE RE-EMERGENCE OF MIDWIFERY* 80 (1994).

45. Nancy Ehrenreich, *The Colonization of the Womb*, 43 *DUKE L.J.* 492, 578 (1993).

46. Donna Diers, *Future of Nurse Midwives in American Health Care*, in *NURSING IN THE 1980S: CRISES, OPPORTUNITIES, CHALLENGES* 267, 268 (Linda H. Aiken ed., 1982).

principles of midwifery date back to early civilization, when childbirth was a shared experience of the community, with women aiding each other during labor, delivery, and post-partum.⁴⁷ The first signs of regulated midwifery appeared in England during the Middle Ages, when midwives were appointed and licensed by the church to ensure the “moral character” of birth attendants.⁴⁸ This incarnation of the midwife not only assisted women during labor, but was expected to prevent abortions and infanticide, establish paternity, and perform baptisms—none of which was done for profit.⁴⁹ However, it was around this same time that the practice of medicine began to establish itself as a male-dominated field.⁵⁰ In one telling example, English physicians petitioned Parliament regarding the “worthless and presumptuous women who usurped the profession,” and asked for the imposition of fines and imprisonment on all women who attempted to “use the practyse [sic] of Fisyk [sic].”⁵¹

Midwives—an inherently female-dominated profession by nature—maintained a monopoly on the area of childbirth well into the eighteenth century.⁵² This domination held true in the newly formed American colonies as well, where childbirth remained a communal event, with midwives and other women in the community lending assistance to the delivering mother.⁵³ Physicians generally intervened into childbirth only to perform caesarian sections or to extract stillborn infants.⁵⁴ This hands-off approach was largely due to the “technological simplicity of early medicine,” which meant that physicians could offer little more to a woman in labor than could a midwife.⁵⁵ During this time, there existed a “professional courtesy”

47. BURTCH, *supra* note 44, at 64-65. Midwifery as a profession has been traced back “at least as far” as Jewish captivity in Egypt. DEVRIES, *supra* note 3, at 22.

48. BURTCH, *supra* note 44, at 65. The church also had a major “interest” in regulating midwifery as a means to prevent witchcraft, as church leaders looked with suspicion upon the typical midwife aids of “herbs, potions and spells.” DEVRIES, *supra* note 3, at 23.

49. BURTCH, *supra* note 44, at 65.

50. BARBARA EHRENREICH & DEIRDRE ENGLISH, *WITCHES, MIDWIVES, AND NURSES: A HISTORY OF WOMEN HEALERS* 19 (1973).

51. *Id.* American physicians also joined the cause, as one prominent New York obstetrician urged the government to enact laws to place “midwifery, as all other branches of medical practices . . . in the hands of the medical profession, where it belongs.” LITOFF, *supra* note 38, at 23.

52. BURTCH, *supra* note 44, at 65. See LITOFF, *supra* note 38, at 3 (“Midwifery has been the almost exclusive province of women throughout recorded history.”).

53. Tovino, *supra* note 15, at 63. Midwives of this period would often begin their practices by watching deliveries before slowly integrating themselves into a “more active role” in the birthing processes. *Id.*

54. BURTCH, *supra* note 44, at 65.

55. Tovino, *supra* note 15, at 64.

between midwives and physicians, where the former were generally left undisturbed to assist in childbirth.⁵⁶

However, this courtesy began to wane as universities—to which women were largely excluded—began teaching the practice of gynecology and surgery.⁵⁷ Innovations such as anesthesia and obstetrical forceps became available to physicians and—“as forceps were legally classified as a surgical instrument,” requiring a medical degree to utilize—the tools were off-limits to women.⁵⁸ Moreover, the medical field—rank with lack of diversity—began to view midwives as competition.⁵⁹ Allowing such a contingent to practice in the field not only deprived doctors of the experience they needed under this new gynecological science, but promoted the idea that an uneducated person could perform the work of a medical professional.⁶⁰ Childbirth had become a lucrative business, and physicians were on the cusp of staking an official claim in the market.⁶¹ As late as 1900, approximately half of all births in the United States were midwife-attended home births, and by 1950 more than eighty percent of all deliveries occurred in hospital settings, under the direct supervision of a doctor.⁶²

The methods and philosophies of midwives and physicians stand in vivid contrast to each other.⁶³ Proponents argue that midwives believe that pregnancy and childbirth are normal, natural processes for women.⁶⁴ Under this viewpoint, a laboring mother should receive encouragement and assistance from a midwife and her family in a “natural and comfortable” home environment, but only “occasional” guidance rather than direct supervisory control.⁶⁵

56. *Id.* (citing LAUREL THATCHER ULRICH, *A MIDWIFE'S TALE: THE LIFE OF MARTHA BALLARD, BASED ON HER DIARY, 1785-1812* 58 (1991)).

57. BURTCH, *supra* note 44, at 65. See LITOFF, *supra* note 38, at 9 (describing early medical schools established in the United States which limited enrollment to male students).

58. EHRENREICH & ENGLISH, *supra* note 50, at 20. See LITOFF, *supra* note 38, at 19 (noting that many were opposed to anesthesia at its inception, as they believed that the pain and suffering of childbirth was what caused women to love their children).

59. Tovino, *supra* note 15, at 66.

60. *Id.* (quoting ULRICH, *supra* note 56, at 254).

61. See EHRENREICH & ENGLISH, *supra* note 50, at 20 (“[I]n the [seventeenth] and [eighteenth] centuries it was possible for male practitioners to make serious inroads into that last preserve of female healing—midwifery.”).

62. Tovino, *supra* note 15, at 67.

63. Hermer, *supra* note 11, at 330.

64. *Id.* at 332.

65. Michael A. Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 BRANDEIS J. FAM. L. 609, 609 (1997).

The physician approach, on the other hand, is viewed as more “disease-oriented.”⁶⁶ The medical theory, according to the pro-midwife faction, presupposes that birth is a series of risks that medical doctors must “systemize, control, and fit into an established time frame.”⁶⁷ This “no case is normal until it is over” viewpoint has historically played well in legislative hearings and through expert testimony in the courts.⁶⁸ These talking points have contributed invaluably to the wellspring of regulatory legislation and midwifery prosecutions in the past century.⁶⁹ However, that regulations requiring licensure and training have been imposed on lay midwives begs the question of whether the law even *needs* to hold midwives to a certain standard of care.⁷⁰

C. THE STATISTICAL BEDROCK OF THE PHYSICIAN—MIDWIFERY APPROACHES

Many studies show that midwife-attended births are “just as safe, if not safer than, medical care in *low-risk* childbirth.”⁷¹ In fact, a report by the Department of Consumer Affairs stated that services provided by both lay and nurse-midwives tended toward lower infant morbidity and mortality rates.⁷² The California Legislature, in an attempt to lessen restrictions on lay midwives, made findings that stressed the “good outcomes” and “cost effectiveness” of birthing with midwifery assistance.⁷³

One of the most comprehensive studies, conducted in 2000 by members of the Public Health Agency of Canada and the International Federation of Gynecology and Obstetrics, surveyed over 5400 women

66. Hermer, *supra* note 11, at 332. One physician colorfully described the “abnormal” nature of childbirth as follows:

If a woman falls on a pitch-fork, and drives the handle through her perineum, we call that pathologic—abnormal, but if a large baby is driven through her pelvic floor, we say that is natural, and therefore normal. If a baby was to have its head caught in a door very lightly, but enough to cause a cerebral hemorrhage, we would say that is decidedly pathologic, but when a baby’s head is crushed against a tight pelvic floor, and a hemorrhage in the brain kills it, we call this normal. . . . I have often wondered whether Nature did not deliberately intend women to be used up in the process of reproduction, in a matter analogous to that of the salmon, which dies after spawning.

DEVRIES, *supra* note 3, at 41.

67. Pike, *supra* note 65, at 609-10.

68. Hermer, *supra* note 11, at 329-30.

69. *Id.*

70. See discussion *infra* Part II.C (discussing the reasons why regulations have been placed on the midwifery profession).

71. Hermer, *supra* note 11, at 326 (emphasis added).

72. Tovino, *supra* note 15, at 94.

73. *Id.* at 97-98 (citing Act of Sept. 1, 2000, ch. 303, 2000 Cal. Adv. Legis. Serv. 303, § 4(d), at 2137 (Deering)).

across North America to evaluate the safety of home births involving lay midwives.⁷⁴ Of the mothers involved in the study, 12.1% required transfer to a hospital either during or directly after giving birth.⁷⁵ While no maternal deaths occurred, there were eleven infant deaths—roughly two deaths per 1000 intended home births.⁷⁶ The study pointedly observed that the low rate of infant mortality was similar to that occurring in low-risk hospital births.⁷⁷

Another finding of the study, stressed repeatedly by midwifery supporters, involved the low rates of intervention occurring during midwife-assisted home births.⁷⁸ Some argue that most obstetrical interventions during labor and delivery have “little, if any, effect” on maternal and infant mortality and morbidity.⁷⁹ For example, caesarean sections have been attacked as problematic, causing deaths due to anesthetic accidents, hemorrhage and infection, as well as urinary tract infections, and nonfatal complications of blood clots.⁸⁰ These procedures occur in 19% of hospital births, but appear in only 3.7% of home births.⁸¹ Episiotomies—incisions made into the opening of the vagina to preserve the pelvic floor during labor and prevent trauma to the fetus’s head—have been maligned as yielding no real benefits to either mother or infant, but rather increasing the risk of incontinence and severe tears.⁸² The episiotomy rate is 10.9% for hospital births, and 3.8% for home births.⁸³

The study noted that a final advantage of home births is the significantly reduced financial cost involved.⁸⁴ On average, an uncomplicated

74. Johnson & Daviss, *supra* note 18, at 1. The breadth of the study was furthered by the fact that NARM made participation in the study mandatory as a prerequisite for recertification. *Id.*

75. *Id.* at 2. According to the study, of the women who intended to have a home birth from the beginning of the pregnancy, the participants were on average older, of a lower socio-economic status, had more advanced educational degrees, and were less likely to be African-American or Hispanic. *Id.* Of the 83.4% who were transferred before delivery, over half were due to failure to progress, pain relief, or exhaustion. *Id.* For those women who were transferred after delivery, the reasons included maternal hemorrhage, retained placentas, and respiratory problems in the newborn. *Id.* The midwives involved in the study considered only 3.4% of the transfers to be “urgent.” *Id.*

76. *Id.*

77. *Id.* at 4.

78. *Id.* at 2.

79. Hermer, *supra* note 11, at 342.

80. *Id.* at 343.

81. Johnson & Daviss, *supra* note 18, at 2.

82. Hermer, *supra* note 11, at 345 n.131. Studies conducted on more holistic alternatives to episiotomy—such as the use of oils and lubricants, massage and manual support, and warm compresses—have yielded varying results. Patricia Aikins Murphy & Julie Baker Feinland, *Perineal Outcomes in a Home Birth Setting*, 25 BIRTH 226, 233 (1998).

83. Johnson & Daviss, *supra* note 18, at 1418.

84. *Id.* at 1419.

vaginal birth in a United States hospital costs three times as much as a similar home birth with a midwife.⁸⁵ A large part of this cost is due to the “routine use” of intervention procedures.⁸⁶ During the North Dakota legislative hearings on Senate Bill 2377, one midwife-supporter, who had previously undergone three home births, testified that she was never charged a flat fee; rather, the rate for her midwife was informally based on “whatever they could pay.”⁸⁷

However, economical analyses and statistical similarities between midwives and physicians do not automatically favor the dispensing of midwifery regulations. Midwife supporters readily admit that a multitude of problems may arise.⁸⁸ The supporters simply contend that complications arise in only 10% of births, and such problems should not require excessive scrutiny on the field of midwifery.⁸⁹ However, one in ten births will by necessity still require some form of intervention that an ill-equipped or improperly trained midwife may not be fully prepared to handle.⁹⁰

Furthermore, at least one study has shown that physicians are far more successful than midwives when certain complications are present.⁹¹ The study also showed that the infant mortality rate is over three times higher in home births involving post-date, twin, or breech deliveries.⁹² While midwives may try to screen out women with high-risk pregnancies early, there is no surefire method that can readily predict if or when a seemingly low-

85. *Id.* One study conducted in 1998 found that the cost of home births ranged anywhere from \$800 to \$4500. Rondi E. Anderson & David A. Anderson, *The Cost-Effectiveness of Home Birth*, 44 J. NURSE MIDWIFERY 30, 32 (1999). The average hospital birth in 1998 was estimated at approximately \$7567. *Id.* at 33.

86. Johnson & Daviss, *supra* note 18, at 1419. See Hermer, *supra* note 11, at 342 (“[Interventions] are costly, both in their own right and in the cascade of subsequent interventions to which the use of some can lead.”).

87. Senate Committee Hearings, *supra* note 3, at 4 (testimony of Becky Olsen). See House Committee Hearings, *supra* note 6, at 13 (testimony of Summer Joy Peterson) (arguing that it is important for North Dakota ranchers and farmers to have as many children as they want, and to not have to limit family size because of costs).

88. See Hermer, *supra* note 11, at 330 (acknowledging fetus malpresentation, entanglement of fetus in umbilical cord, fetus respiratory or cardiac distress, stuck shoulders, ruptured uterus, severely torn perineum, and pulmonary embolism of mother as problems that can arise in childbirth).

89. See *id.* (“The fact that none of these or other complications arise in [90%] of all births makes no difference to most physicians, who believe one must be as well prepared as possible for the [10%] of births in which there are problems.”).

90. Cf. MINN. STAT. § 147D.05(2) (2007) (requiring that midwives form an emergency plan that would detail the underlying conditions necessitating hospital transfers, as well as procedures for moving a mother to a hospital environment).

91. Lewis Mehl-Madrona & Morgaine Mehl Madrona, *Physician and Midwife-Attended Home Births: Effects of Breech, Twin and Post-Dates Outcome Data on Mortality Rates*, 42 J. NURSE MIDWIFERY 91, 95 (1997).

92. *Id.*

risk pregnancy may turn into a high-risk one.⁹³ Many states have opted not to leave such complications to chance and have constructed regulations on the profession to ensure the welfare of mothers and newborns alike.⁹⁴

Home births attended by midwives have generally been shown to be as safe as hospital births overseen by medical professionals.⁹⁵ However, in many cases an untrained midwife will be ill equipped to handle problems that do arise.⁹⁶ When such incidents occur, or when midwives attempt to circumvent non-midwife-friendly statutes, the fate of their practice rests in the hands of the law.⁹⁷

III. MIDWIVES IN THE LEGAL SYSTEM

Each state has the power to regulate midwives operating within its borders, and may do so by permitting them to practice, restricting how they practice, or prohibiting them entirely.⁹⁸ The states have not been uniform in their approach to midwifery, which has resulted in a rainbow of various laws defining the practice across the country.⁹⁹ Through the action or inaction of the states, midwives necessarily find themselves within the legal system, whether through statutory regulations, prosecutions for violating state statutory law, or from challenges against the regulations placed upon them.

A. THE STATUTORY REGULATION OF MIDWIVES

The sole common denominator between the states in the regulation of midwives is that all fifty states allow nurse-midwives to practice under physician supervision or collaboration.¹⁰⁰ State regulation of lay midwives,

93. Hermer, *supra* note 11, at 332. One study on client screening cautions that risk assessment is an “ongoing process,” and that factors which need to be considered include the woman’s predilection to accept responsibility for self-care, her support network during the childbearing cycle, and the presence or absence of any medical factors that could require hospitalization. Saraswathi Vedam & Yelena Kolodji, *Guidelines for Client Selection in the Home Birth Midwifery Practice*, 40 J. NURSE MIDWIFERY 508, 509 (1995).

94. See discussion *infra* Parts III.A & III.C (discussing the statutory schemes established by various states and their subsequent constitutional victories).

95. Hermer, *supra* note 11, at 326.

96. Mehl-Madrona & Mehl Madrona, *supra* note 91, at 95.

97. See Hermer, *supra* note 11, at 355 (discussing potential midwifery prosecutions); Corcoran, *supra* note 17, at 661 (discussing midwife attempts to challenge restrictive statutes).

98. Tovino, *supra* note 15, at 68.

99. See Joleen Susan Pettee, *Midwifery: Do Parents Have a Constitutional Right to Choose the Site, Process, and Attendant for the Birth of Their Baby?*, 24 J. CONTEMP. L. 377, 377 (1998) (“[T]he practice of midwifery varies across the nation depending on the legality of the practice and the licensing requirements of particular states.”).

100. Hermer, *supra* note 11, at 349.

however, varies from jurisdiction to jurisdiction.¹⁰¹ According to a survey compiled by MANA in April 2007, twenty-four states allow lay midwives to practice by licensure, certification, registration, or permit, while ten states prohibit lay midwives from practicing within the jurisdiction completely.¹⁰² In the sixteen remaining states, the legal status of lay midwifery is essentially undetermined.¹⁰³ Four states do not legally regulate midwives but also do not prohibit them.¹⁰⁴ Ten states allow midwives to practice only by judicial or statutory interpretation.¹⁰⁵

1. *States Which Legislate, Certify, Register, or Permit Lay Midwifery*

Licensure of lay midwives is the most direct form of control over the profession, the primary justification for which is protection from unqualified, incompetent practitioners.¹⁰⁶ In many instances, lay midwives who are currently practicing welcome licensure, believing that it can help insure their professional future and the quality of their work.¹⁰⁷ Of those states which license lay midwives, the specific entry and practice requirements vary substantially.¹⁰⁸

101. DEVRIES, *supra* note 3, at 18.

102. Direct-Entry Midwifery State-by-State Legal Status, <http://www.mana.org/stchartfrm.html> [hereinafter MANA chart] (last visited Jan. 14, 2007). The states which regulate midwives through licensure, certification, and registration of permit are Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Louisiana, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin. *Id.* However, some commentators argue that Georgia and Hawaii make it practically impossible for midwives to practice by constructing the requirements in a way that is "virtually identical" to those imposed upon nurse-midwives. Hermer, *supra* note 11, at 356. The states which prohibit lay midwives are Alabama, Illinois, Indiana, Iowa, Kentucky, Maryland, Missouri, North Carolina, South Dakota, and Wyoming. MANA chart, *supra* note 102. The District of Columbia also prohibits lay midwifery. *Id.*

103. Hermer, *supra* note 11, at 356.

104. MANA chart, *supra* note 102. The states which do not legally regulate midwives are Connecticut, Nebraska, Ohio, and West Virginia. *Id.*

105. *Id.* Joining North Dakota in allowing lay midwifery only by judicial or statutory interpretation are Idaho, Kansas, Maine, Massachusetts, Michigan, Mississippi, Nevada, Oklahoma, and Pennsylvania. *Id.*

106. Corcoran, *supra* note 17, at 656-57. While many believe that licensing is an effective way of regulating the profession, some commentators point to studies which suggest that licensing boards tend to take action against practitioners in the medical field only rarely. DEVRIES, *supra* note 3, at 6-7. These commentators conclude that the overall effect of disciplinary action is then rendered "insignificant." *Id.*

107. DEVRIES, *supra* note 3, at 30.

108. Corcoran, *supra* note 17, at 658. See Chris Hafner-Eaton, *Birth Choices, the Law, and Medicine: Balancing Individual Freedoms and Protection of the Public's Health*, 19 J. HEALTH POL. POL'Y & L. 813, 826 (1994) (noting how midwifery regulations vary due to the broad powers of the states in passing laws pertaining to the public's health).

California did not regulate lay midwives until the California Licensed Midwifery Practice Act of 1993.¹⁰⁹ This law established the scope of practice of a licensed midwife and permitted midwives to attend home births only under the supervision of a licensed physician with a current practice or training in obstetrics.¹¹⁰ The supervising physician need not be physically present while the midwife attends to the mother, but must have “reasonable geographic and/or temporal proximity to the patient” in case of emergency.¹¹¹

To qualify for licensure in California, a midwife must successfully complete a three-year postsecondary midwifery education program and pass a licensing examination.¹¹² The statute also requires that lay midwives provide written and oral disclosures to any prospective client.¹¹³ These disclosures include whether the midwife has liability coverage and specific arrangements for transferring the client to a hospital in case of emergency.¹¹⁴

Minnesota provides another example of statutory licensing of lay midwives.¹¹⁵ The state code specifically lists which activities do not fall under the practice of “traditional” midwifery.¹¹⁶ Lay midwives are required to screen each client and only accept those who are expected to have a normal delivery.¹¹⁷ The code also provides that stringent client records are maintained.¹¹⁸ To be eligible for licensure in Minnesota, a midwife must submit: (1) a detailed application; (2) a diploma from an approved education program or evidence of completing an apprenticeship; (3) a verified copy of a NARM-issued credential; (4) cardiopulmonary resuscitation

109. CAL. BUS. & PROF. CODE §§ 2505-08, 2511-2515.5, 2517-2521 (Deering 2004). *See* Tovino, *supra* note 15, at 94-95 (noting the absence of lay midwifery regulations under 1993).

110. Tovino, *supra* note 15, at 94-95.

111. Hermer, *supra* note 11, at 353.

112. CAL. BUS. & PROF. § 2512.5(a) (West 2007). The statute further details a specific curriculum that midwives must complete during the education program, which includes: the art and science of midwifery, communication skills, anatomy and physiology, obstetrics and gynecology, human sexuality, aspects of normal pregnancy, family planning, newborn care, and breastfeeding. *Id.* § 2512.5(a)(3)(A)-(H).

113. *Id.* § 2508(a).

114. *Id.*

115. *See* MINN. STAT. § 147D.01-27 (2007) (establishing licensing procedures and restrictions on midwives within the state).

116. *Id.* § 147D.03(3). The statute bars the use of any surgical instrument at childbirth except to sever the umbilical cord or repair a first or second degree perineal laceration, assist in childbirth by artificial or mechanical means and remove the placenta accrete. *Id.*

117. *Id.* § 147D.05(1)-(4).

118. *Id.* Such records must include a copy of an informed consent form, evidence of an initial client screening, a copy of a written plan for the pregnancy and protocol for a hospital transfer, a record of prenatal and postpartum care, and a detailed record of the labor and delivery process. *Id.*

(CPR) certification; (5) a medical consultation plan; (6) documentation verifying practical experience; and (7) any other information requested by the board.¹¹⁹

Some midwifery advocates argue that, even among the states which legally authorize lay midwifery, regulations and requirements can be so extensive as to actually inhibit the practice.¹²⁰ Generally, however, lay midwives who follow the regulations in these states may at least be assured that their actions during a home birth will not land them in legal trouble.¹²¹ Midwives do not fare as well in states which outlaw the practice out of a belief that midwifery is contrary to the legitimate practice of medicine.¹²²

2. *States Which Prohibit Lay Midwifery*

In the ten states that prohibit the practice of lay midwifery, women who wish to deliver their children at home, and the midwives who help them, must do so secretly lest they face prosecution for their actions.¹²³ Practicing lay midwifery in these states is essentially the same as practicing medicine without a license.¹²⁴ As a result, these states often serve as key locations for lay midwives and their proponents as they seek to establish legitimacy in the system.¹²⁵

One of the most contentious areas regarding legislative action has been in Missouri, where lay midwives—equated to a “shadow network” due to their inability to practice in the open—have fought for two decades to ease state regulations which limit midwifery to nurses.¹²⁶ In the 2007 legislative session, Missouri lawmakers introduced Senate Bill 303 to create a licensing board for lay midwives.¹²⁷ The bill would have provided for the licensure of any midwife who could provide evidence of certification by NARM and certification in basic life support and CPR.¹²⁸ Additionally, to

119. *Id.* § 147D.17(1). Minnesota also provides that lay midwives may practice within the state through reciprocity or a temporary permit. *Id.* § 147D.17(2)-(3).

120. Kerry E. Reilley, *Midwifery in America: The Need for Uniform and Modernized State Law*, 20 SUFFOLK U. L. REV. 1117, 1130 (1986). Georgia is an oft-cited example of this overregulation, as the state makes the requirements for lay midwives “virtually identical” to those for nurse-midwives. Hermer, *supra* note 11, at 356.

121. DEVRIES, *supra* note 3, at 45.

122. Hafner-Eaton, *supra* note 108, at 821.

123. Hermer, *supra* note 11, at 356.

124. Heitzman, *supra* note 2, at A12.

125. Hermer, *supra* note 11, at 355.

126. *Id.* See Virginia Young, *Judge Rejects New Midwifery Law on a Legal Technicality*, ST. LOUIS POST-DISPATCH, Aug. 9, 2007, at B1 [hereinafter “Young I”] (“Midwifery advocates have battled for two decades to ease state regulations that limit the practice of midwifery to certain specialized nurses, working in collaboration with doctors.”).

127. S. 303, 94th Gen. Assem., Reg. Sess. (Mo. 2007).

128. *Id.*

become licensed, a midwife would be required to pay a fee and provide written disclosure forms to all clients.¹²⁹ However, the bill quickly met fierce opposition, with one legislator, Senator Chuck Graham, remarking: “I just don’t trust someone taking an Internet course and then the state saying, ‘Hey, go deliver babies.’”¹³⁰

Following the bill’s failure, its sponsor, Senator John Loudon, tucked its language into a health insurance bill and substituted the obscure Greek term “tocology” for any reference to midwifery.¹³¹ The bill was immediately challenged.¹³² Physicians’ groups argued that the law went beyond the bill’s title.¹³³ Additionally, the attorney general’s office contended that the bill’s purpose was to improve health care, which midwifery services would help accomplish.¹³⁴ A circuit court judge agreed with the bill’s opponents, holding that the title was too narrow to encompass midwifery and struck it down as unconstitutional.¹³⁵

The fierce contest in Missouri mirrors the attitudes in the other nine states that prohibit lay midwifery.¹³⁶ In those states, opponents state that the practice presents “grave and unacceptable risks,” while midwives argue that they are being assaulted by a male-dominated medical field that resents the tradition.¹³⁷ Within this unstable climate, many lay midwives have begun to support the idea of licensure, believing that limitations on a legalized profession would greatly outweigh having to operate under the threat of prosecution.¹³⁸ While the conflict rages on, it is likely that the lay midwives within these states will continue to assist in childbirth without legal sanction.¹³⁹

129. *Id.*

130. Heitzman, *supra* note 2, at A12.

131. H. 818, 94th Gen. Assem., Reg. Sess. (Mo. 2007); Virginia Young, *Doctors Trying to Block Midwives Law Cite Obscure Wording*, ST. LOUIS POST-DISPATCH, August 3, 2007, at C3 [hereinafter Young II].

132. Young II, *supra* note 131, at C3.

133. *Id.*

134. *Id.*

135. Young I, *supra* note 126, at B1.

136. *See* Liptak, *supra* note 16, at A12 (discussing the clashes between lay midwifery supporters and opponents in the states which outlaw the practice).

137. *Id.*

138. Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 LAW & SOC’Y REV. 125, 135 (2005).

139. Wolfson, *supra* note 21, at 930.

3. *States That Leave the Legal Status of Lay Midwifery Undetermined*

The states that do not regulate or prohibit lay midwifery, as well as those that allow lay midwifery only by judicial or statutory interpretation, do not restrict midwives from practicing within the state.¹⁴⁰ However, these states also fail to provide a legal safety net in case something goes wrong.¹⁴¹ While they are technically allowed to practice, midwives operating in states with “dubious” laws face the heightened possibility of being reported for practicing medicine or nursing without a license.¹⁴² Consequently, their ability to work within their home states is rife with complication and tenuous at best.¹⁴³

In those states where lay midwives are allowed to practice by judicial or statutory interpretation without further regulation or oversight, midwives are technically given legal sanction to practice their trade.¹⁴⁴ This means that midwives cannot be prosecuted for the unlicensed practice of medicine when assisting in a normal birth without using drugs or interventions.¹⁴⁵ However, their scope of practice is left undefined, leaving midwives open to charges of unlawfully practicing medicine if they do intervene or administer any controlled substance.¹⁴⁶ In those states that neither regulate nor prohibit lay midwifery, lay midwives are left even more exposed, and any action performed while attending a home birth could be potentially viewed as the practice of medicine.¹⁴⁷

The approaches toward licensing and regulating lay midwives vary substantially between the states.¹⁴⁸ An individual wishing to practice lay midwifery would need to check the appropriate state code to discover whether their occupation is permitted, prohibited, or allowed only because

140. Hermer, *supra* note 11, at 355-56. The concepts of judicial and statutory interpretation are essentially interrelated, meaning that the courts interpret midwifery statutes and conclude that midwifery does not constitute the practice of medicine. *Id.* See Amy Cohen, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 852 n.11 (2005) (describing the process of statutory interpretation); see also Hafner-Eaton, *supra* note 108, at 821 (noting that in these states, lay midwives are allowed to practice so long as their actions do not constitute the unauthorized practice of medicine).

141. Hermer, *supra* note 11, at 355-56.

142. See Beckett & Hoffman, *supra* note 138, at 134 (discussing the tendency of medical personnel to report midwives to legal authorities).

143. Hermer, *supra* note 11, at 355-56.

144. *Id.* at 355.

145. *Id.*

146. *Id.*

147. *Id.* at 356. This is also true of states where there has been no construal of existing law which in any way sanctions the actions of lay midwives. *Id.*

148. Corcoran, *supra* note 17, at 657.

their legal status is undetermined.¹⁴⁹ The necessity of knowing a particular state's laws is imperative, because a midwife who violates the law would be susceptible to prosecution.¹⁵⁰

B. THE PROSECUTION OF MIDWIVES

Actions against midwives typically arise when medical and nursing boards allege that a midwife is practicing medicine, nursing, or nurse-midwifery without a license.¹⁵¹ However, these actions usually do not occur unless an infant or mother dies during a midwife-assisted birth.¹⁵² Additionally, prosecutions typically occur in states which either prohibit lay midwifery, or leave their legal status undetermined.¹⁵³ These prosecutions may hinge upon a variety of issues, including whether childbirth can be considered a medical condition, whether a midwife has contravened statutory law, and whether a midwife has violated a standard of care to her patient.¹⁵⁴

Several courts have considered the question of whether childbirth could be considered a medical condition.¹⁵⁵ In *State v. Smith*,¹⁵⁶ an unlicensed lay midwife performed several medical procedures during a birth.¹⁵⁷ The procedures included internal vaginal examinations, pelvis measurements, fetal heartbeat monitoring, and blood and urine examinations.¹⁵⁸ The court found that the practice of midwifery without a license was tantamount to practicing medicine without a license.¹⁵⁹ The court based its decision on the determination that childbirth itself was a medical condition since it

149. Hermer, *supra* note 11, at 353.

150. *Id.* at 355.

151. Corcoran, *supra* note 17, at 661. Shelby County Prosecutor R. Kent Apsley, who orchestrated a 2006 case against an Indiana midwife, compared lay midwives to truck drivers who operate their vehicle without a license. Liptak, *supra* note 16, at A12. He remarked: "He may be doing an awfully fine job of driving the truck . . . [b]ut the state requires him to go through training, have his license and be subject to review." *Id.*

152. Liptak, *supra* note 16, at A12.

153. Hermer, *supra* note 11, at 355.

154. See discussion *infra* Part III.B (discussing issues arising out of midwifery prosecutions).

155. See, e.g., *Smith v. State*, 459 N.E.2d 401, 404-05 (Ind. Ct. App. 1984) (holding that the cessation of pregnancy is a medical condition); *Bowland v. Mun. Court for Santa Cruz Judicial Dist.*, 556 P.2d 1081, 1089 (Cal. 1976) (holding that the treatment of childbirth is at least a "physical condition" as contemplated under state statute).

156. 459 N.E.2d 401 (Ind. Ct. App. 1984).

157. *Smith*, 459 N.E.2d at 404.

158. *Id.* See *State ex rel. Mo. State Bd. of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219, 221 (Mo. 1986) (involving a situation where a midwife was prosecuted for similar procedures).

159. *Smith*, 459 N.E.2d at 404-05.

involved the “cessation or termination of the condition known as pregnancy.”¹⁶⁰

The classification of “childbirth” also became an issue in *Bowland v. Municipal Court for Santa Cruz County Judicial District*,¹⁶¹ where the appellant midwife argued that a California statute, which barred the practice of medicine without a license, did not apply to midwifery.¹⁶² The appellant reasoned that a woman who is pregnant or undergoing childbirth is not “sick or afflicted” within the meaning of the provision.¹⁶³ The court disagreed, however, and held that complications arising during pregnancy certainly qualified as sickness and affliction.¹⁶⁴ The court further clarified that even if childbirth did not qualify under this provision, it certainly satisfied the statute’s licensure requirement for any treatment of a “physical condition.”¹⁶⁵

Actions against lay midwives have also arisen under circumstances where a midwife has been accused of contravening statutory law.¹⁶⁶ In *Devers-Scott v. Office of Professional Regulation*,¹⁶⁷ the appellant midwife first argued that the administrative law officer erred in finding that she improperly maintained her client charts by bringing along an incomplete chart on a hospital transfer.¹⁶⁸ Primarily, the appellant argued that the staff at the hospital did not review the chart, which would indicate that the improperly kept chart did not contribute to the infant’s death.¹⁶⁹ The court disagreed, stating that since the law only required a complete chart and did not contain an “adverse-outcome condition,” a midwife violated the law solely by failing to maintain the records, and not because the failure to maintain proximately contributed to the plight of a patient.¹⁷⁰ The appellant

160. *Id.* The statute dealt with the licensing of midwives, and stated in part that a “midwifery license is subject to suspension, revocation, retirement or surrender for the same reasons as provided in the case of physicians’ licenses.” IND. CODE § 25-22-5-5-5 (repealed 1993). Since *Smith*, Indiana has enacted legislation specifically limiting the practice of midwifery to registered nurses. See IND. CODE ANN. § 25-23-1-13.1 (2007) (requiring those who wish to practice midwifery to hold a license as a registered nurse).

161. 556 P.2d 1081 (Cal. 1976).

162. *Bowland*, 556 P.2d at 1084. See CAL. BUS & PROF. § 2141 (amended 1985) (stating in the original version of the statute that a person who treats the sick or afflicted without a license is guilty of a misdemeanor).

163. *Bowland*, 556 P.2d at 1084.

164. *Id.* at 1085.

165. *Id.* at 1089.

166. See, e.g., *Devers-Scott v. Office of Prof’l Regulation*, 918 A.2d 230, 235-37 (Vt. 2007) (holding that a midwife improperly maintained charts and did not provide competent and safe patient care).

167. 918 A.2d 230 (Vt. 2007).

168. *Devers-Scott*, 918 A.2d at 235-36.

169. *Id.*

170. *Id.* at 236.

next contended that she had not violated a rule requiring physician consultation in certain circumstances, since the client's fluid discharge was not one of the fourteen triggers for consultation or transfer specified in the rule.¹⁷¹ The court struck down this argument as well, noting that the appellant had violated a broader provision, which simply required that a midwife provide "competent and safe patient care" in similar situations.¹⁷²

Further reflecting how broadly the courts will interpret the law when dealing with midwifery prosecutions, the court in *O'Conner v. State of Washington Department of Health*¹⁷³ held that lay midwives should be held to the same standard of care as a nurse-midwife.¹⁷⁴ In *O'Conner*, the appellant was accused of disregarding a reasonable health care provider's duty to make recommendations to a client to enable them to make safe and effective health care decisions.¹⁷⁵ The court noted that "the single most important concern in midwifery practice is safety."¹⁷⁶ As a result, the court upheld the agency's finding that there should be no difference in the care a midwife provides, regardless of whether he or she provides hospital-based interventionist care or non-interventionist, patient-oriented care.¹⁷⁷

While even some midwifery opponents have expressed their hesitation over prosecuting midwives, the practice still exists, and at times can be rigorous.¹⁷⁸ To date, prosecutions against midwives have been attempted in half of the states.¹⁷⁹ However, midwives have often taken the law into their own hands, and have tried to challenge the constitutionality of the regulations imposed upon them.¹⁸⁰

171. *Id.* Within the state's Administrative Rules for Licensed Midwives, Vermont enumerates fourteen circumstances that require a midwife to transfer patients to a hospital or consult with a physician. 04-030-360 VT. CODE R. § 3.14.3 (2007). These "triggers" include unforeseen multiple fetuses, a prolapsed umbilical cord, and an infant with abnormal vital signs. *Id.*

172. *Devers-Scott*, 918 A.2d at 236-37.

173. No. 54835-2-I, 2005 WL 2338685 (Wash. App. Div. Sept. 26, 2005).

174. *O'Conner*, 2005 WL 2338685, at *4.

175. *Id.* at *3.

176. *Id.* at *4.

177. *Id.* at *3. *But see* DEVRIES, *supra* note 3, at 5 (arguing that establishing a standard of care limits experimentation with new techniques).

178. Darryl K. Brown, *Democracy and Decriminalization*, 86 TEX. L. REV. 223, 239-40 (2007). In one example of how far states have gone to prosecute midwives, California once set up a series of sting operations to arrest midwives practicing without a license. *Id.* at 239.

179. Beckett & Hoffman, *supra* note 138, at 134.

180. *See generally* Reilley, *supra* note 120, at 1131-42 (detailing various constitutional challenges brought by midwives against regulatory statutes).

C. THE CONSTITUTION AND MIDWIFERY LAW

While many midwifery-related actions arise from government agencies intending to prosecute or revoke the licenses of lay midwives, some actions are actually raised by midwives themselves.¹⁸¹ In initiating these actions, midwives hope to overturn “restrictive statute[s] or to clarify” what they consider to be “ambiguit[ies] in the law.”¹⁸² These actions generally take the form of constitutional challenges brought under the principles of due process, privacy, and void-for-vagueness.¹⁸³ A survey of these cases reveals the courts’ pattern of upholding midwifery regulations in a near-unanimous fashion.¹⁸⁴

1. *Due Process Challenges*

The right to follow a chosen profession is a property interest protected by the Fifth and Fourteenth Amendments.¹⁸⁵ In *Sammon v. New Jersey Board of Medical Examiners*,¹⁸⁶ the Third Circuit Court of Appeals considered whether a New Jersey statute requiring licensing, the successful completion of an examination, and a physician-endorsed application, violated the constitutional rights of midwives who wished to legally practice within the state.¹⁸⁷ The appellant midwife argued that the statute deprived midwives of their right to work in a chosen profession and prevented parents from choosing the birthing style and attendant of their choice.¹⁸⁸

In determining the level of scrutiny to apply, the court noted that the statute did not prohibit midwifery, nor limit where or how birthing may take

181. Corcoran, *supra* note 17, at 661.

182. *Id.*

183. *See* Hermer, *supra* note 11, at 327 (noting generally that some lay midwives challenge regulatory statutes on constitutional grounds). While constitutional challenges are certainly the most common actions brought by lay midwives, other forms do arise. In 2007, an Oregon midwife, whose privileges to deliver babies were revoked (for undisclosed reasons), filed an anti-trust lawsuit against the hospital, claiming that her dismissal was simply the effort of a business trying to eliminate competition in the birthing market. Colin Fogarty, *Salem Hospital Sends Midwives Packing*, Oregon Public Broadcasting (2007), www.publicbroadcasting.net/opb/news.newsmain?action=article&ARTICLE_ID=1090088 (last visited Jan. 14, 2007). Challenges have also been made—although rarely—under the Equal Protection Clause. *See* State v. Kimpel, 665 So. 2d 990, 994 (Ala. Crim. App. 1995) (striking down an Equal Protection argument under rational basis review because midwives are not a suspect class).

184. *See* discussion *infra* Part III.B.1-2 (detailing unsuccessful constitutional challenges to statutes).

185. *Lange-Kessler v. Dep’t of Educ.*, No. 96-7632, 1997 U.S. App. LEXIS 15275, *6 (2d. Cir. Mar. 26, 1997). The Fifth and Fourteenth Amendments dictate that no state shall “deprive any person of life, liberty, or property without due process of law.” U.S. CONST. amend. V, XIV.

186. 66 F.3d 639 (3d Cir. 1995).

187. *Sammon*, 66 F.3d at 641.

188. *Id.* at 644.

place.¹⁸⁹ Rather, the court held that the statute only regulated the qualifications of the individuals who may practice midwifery.¹⁹⁰ Concluding that this regulation did not implicate a fundamental right, the *Sammon* court applied a rational basis review to determine whether the New Jersey Legislature could have rationally concluded that a legitimate state interest would be served by the statute.¹⁹¹ The court first noted there was a legitimate interest in protecting the health and welfare of mothers and children within the state.¹⁹² Furthermore, the court recognized that educational requirements may further a state's interest in assuring that midwives are qualified to perform their jobs.¹⁹³ The court ultimately held that the regulatory scheme was rationally related to legitimate state interests and struck down the midwife's claim.¹⁹⁴

Also considering the issue of a midwife's due process rights, the court in *Hunter v. State*¹⁹⁵ reiterated the notion that statutory regulations on midwifery did not foreclose parents from engaging midwives or giving birth at home.¹⁹⁶ Instead, the statute merely regulated who may engage in the practice of midwifery, much like statutory regulations on who may practice medicine.¹⁹⁷ The court in *Lange-Kessler v. Department of Education*¹⁹⁸ went even further by citing *Roe v. Wade*¹⁹⁹ for the proposition that protecting the health and welfare of mothers and infants was an "important and legitimate" interest.²⁰⁰ The court also determined that the New York Legislature could have reasonably believed that requiring midwives to complete a nursing program and become affiliated with a medical professional

189. *Id.*

190. *Id.*

191. *Id.* at 645.

192. *Id.* at 646.

193. *Id.*

194. *Id.* In *Lange-Kessler v. Department of Education*, the court had further reason to consider an argument that regulations barred mothers from choosing home births. No. 96-7632, 1997 U.S. App. LEXIS 15275, *13 (2d Cir. Mar. 26, 1997). The appellants argued that the New York regulations—which effectively required an education in nursing for any midwife—would prevent home births altogether, as physicians and nurse-midwives would refuse to attend them due to peer pressure and insurance concerns. *Id.* The court, opting not to reach a conclusion on whether there is a right to choose a home birth, dismissed the argument, stating that the mothers had submitted no evidence indicating that they either sought, or were unable to find, licensed nurse-midwives or physicians to perform a home birth. *Id.* at *14.

195. 676 A.2d 968 (Md. Ct. Spec. App. 1996).

196. *Hunter*, 676 A.2d at 975.

197. *Id.*

198. 1997 U.S. App. LEXIS 15275 (2d Cir. Mar. 26, 1997).

199. 410 U.S. 113 (1973).

200. *Lange-Kessler*, 1997 U.S. App. LEXIS 15275, at *7, 9.

would render them more fit to practice medicine than direct-entry midwives.²⁰¹

Due process challenges have ultimately proved futile, as the courts have consistently found that the right to practice in a chosen profession is not fundamental.²⁰² As such, regulations on midwifery have been shown to bear a rational relation to the protection of public health and safety.²⁰³ The issue of health and safety has bred similar holdings when women have argued a privacy right in utilizing the birth attendant of their choice.²⁰⁴

2. *Privacy Challenges*

The constitutional right to privacy has been expanded over the years to protect certain personal choices relating to childrearing, marriage, procreation, and abortion.²⁰⁵ This logic has also been extended into arguments that midwifery regulations invade upon the privacy rights of a woman giving birth.²⁰⁶ Specifically, midwifery advocates argue that a woman has the fundamental right to choose who will help deliver her child.²⁰⁷

However, privacy claims in midwifery challenges have not fared well due to the general limitations placed upon the constitutional right to

201. *Id.*

202. Reilley, *supra* note 120, at 1131.

203. *Id.* See Leigh v. Bd. of Registration in Nursing, 481 N.E.2d 1347, 1377, 1382-83 (Mass. 1985) (upholding a statute requiring a certificate from a nursing board to practice midwifery).

204. See Reilley, *supra* note 120, at 1142 (noting that courts have found privacy arguments to be unpersuasive).

205. Bowland v. Mun. Court for Santa Cruz County Judicial Dist., 556 P.2d 1081, 1089 (Cal. 1976). The right to privacy has been derived from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments to the Constitution. U.S. CONST. amends. I, IV, V, IX, XIV. The Constitution generally protects all individuals from unjustified state interference. Planned Parenthood of Se. Penn. v. Casey, 505 U.S. 833, 896 (1992). As the United States Supreme Court stated, a person's right to privacy applies not only to the "breaking of his doors, and the rummaging of his drawers . . . but it is the invasion of his indefeasible right of personal security, personal liberty, and personal property." Boyd v. United States, 116 U.S. 616, 630 (1886). This right is spelled out in the Fourth Amendment, which recognizes the right of people to be "secure in their persons, houses, papers, and effects, against unreasonable searches and seizures." U.S. CONST. amend. IV. However, the Court has found a privacy right scattered throughout the rest of the Constitution, whether in the First Amendment's right of association, the Fifth Amendment's protection against self-incrimination, or the Ninth Amendment's guarantee of rights beyond those etched onto the Constitution itself. U.S. CONST. amend. I, V, IX. See Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (describing expansive privacy rights found in the Constitution).

206. Wolfson, *supra* note 21, at 930.

207. Reilley, *supra* note 120, at 1140. More generally, proponents argue that privacy challenges are a perfect vehicle for attacking midwifery statutes, as childbirth by nature implicates intensely personal decisions of women on how to use their body and how to begin their child's life. Barbara A. McCormick, *Childbearing and Nurse-Midwives: A Woman's Right to Choose*, 58 N.Y.U. L. REV. 661, 713 (1983).

privacy.²⁰⁸ These limitations often stem from the regulatory trimester scheme established in *Roe*, which recognized that a state has a greater interest to intervene in a pregnancy during the third trimester.²⁰⁹ Based on this concept, the right to privacy begins to detach from childbirth decisions once the child can be universally considered as a “third person” who will be affected by the decisions of the mother.²¹⁰

In *Connecticut v. Menillo*,²¹¹ the United States Supreme Court considered whether it was appropriate to convict an individual, who was not a physician, for attempting to provide an abortion.²¹² The Court reviewed its previous decisions regarding abortion and noted that a woman has the right to privacy only as long as the procedure is “as safe for the woman as normal childbirth.”²¹³ The Court held that the state’s interest in maternal health justified requiring those who perform such procedures to have medical training.²¹⁴

Therefore, the right to privacy mellows at the time of birth, when the state’s interest in the life and health of the mother and child trumps the mother’s right to choose the manner and circumstances in which a child is born.²¹⁵ The court in *Bowland* applied this logic to midwifery law, stating that the right to privacy has never been interpreted so broadly as to affect when and how a baby is born.²¹⁶ While the California Legislature had never before attempted to require women to give birth in a hospital or with a physician in attendance, the court found that the California Legislature may require those who assist in childbirth to be properly trained and educated to protect the welfare of those involved.²¹⁷

208. See, e.g., *Bowland*, 556 P.2d at 1089 (holding that the right to privacy does not include choosing the manner in which a child is born).

209. Pike, *supra* note 65, at 611. While the *Roe* Court established that a mother has privacy rights that the state may not infringe upon, the Court recognized that the state’s interest in potential human life grows substantially as the woman grows closer to term. *Roe v. Wade*, 410 U.S. 113, 162-63 (1973). The Court elaborated by noting that when a fetus becomes viable, it reaches a “compelling point” where the state’s interest may supersede privacy rights to intervene in the pregnancy. *Id.* at 163.

210. Wolfson, *supra* note 21, at 945.

211. 423 U.S. 9 (1975).

212. *Menillo*, 423 U.S. at 9.

213. *Id.* at 10-11.

214. *Id.* at 11.

215. See *State v. Kimpel*, 665 So. 2d 990, 994 (Ala. Crim. App. 1995) (“When the fetus is viable . . . the mother’s privacy rights are subjugated to the governmental interest in protecting both hers and the child’s safety.”).

216. *Bowland v. Mun. Ct. for Santa Cruz County Judicial Dist.*, 556 P.2d 1081, 1089 (Cal. 1976).

217. *Id.* The *Bowland* court further noted that the policy rationale of protecting a mother and child under the care of a midwife is the same behind prohibiting the abortion of a viable unborn child. *Id.*

The right to choose a midwife can be viewed as a privacy issue under several concepts, including the right of personal autonomy, bodily integrity, and parental authority.²¹⁸ However, midwifery supporters have been unsuccessful in convincing the courts to recognize a privacy right in choosing one's birth attendant.²¹⁹ Even with the difficulty of mounting challenges under theories of due process or privacy, some midwives have been more successful in attacking the language of the statute itself.²²⁰

3. *Void-for-Vagueness Challenges*

While midwives do not fare well in due process or privacy challenges, a more balanced outcome exists when midwifery statutes are attacked on the premise that they are void-for-vagueness.²²¹ Under this test, a statute is rendered void if an accused could not reasonably know that his conduct was prohibited, or if the language of the statute leaves doubt as to which individuals fall within the scope of the law.²²² When courts are persuaded by these arguments, the ambiguous or restrictive language is stripped of its application.²²³ Thus, midwives are exempt from the imposed regulations, and their continued practice without a license is prevented from being deemed illegal.²²⁴

The court sided with the midwives in *Peckmann v. Thompson*²²⁵ when it reviewed an Illinois statute prohibiting unlicensed persons from the "practice of medicine in all of its branches."²²⁶ The court found that the statute did not define this phrase and noted that it did not necessarily encompass assisting the normal delivery of a healthy child.²²⁷ Therefore, the court held that the statute failed to provide reasonable notice to persons of ordinary intelligence that their conduct was illegal.²²⁸ As further

218. Cohen, *supra* note 140, at 869-73.

219. *See id.* at 875 (discussing the courts' refusals to recognize a privacy right in choosing a birth attendant).

220. *See* discussion *infra* Part III.C.3 (discussing more favorable outcomes on vagueness challenges).

221. *See* Cohen, *supra* note 140, at 852-53 n.11 (noting that while constitutional challenges are usually unsuccessful, statutes have been stricken on void-for-vagueness claims).

222. *Parker v. Levy*, 417 U.S. 733, 757 (1974). *See* *United States v. Nat'l Dairy Corp.*, 372 U.S. 29, 32 (1963) (noting a presumption of validity and that the Court will favor interpretations of the statute that support constitutionality); *Boyce Motor Line, Inc. v. United States*, 342 U.S. 337, 340 (1952) ("A criminal statute must be sufficiently definite to give notice of the required conduct to one who would avoid its penalties.").

223. Corcoran, *supra* note 17, at 661.

224. *Id.*

225. 745 F. Supp. 1388 (C.D. Ill. 1990).

226. *Peckmann*, 745 F. Supp. at 1393.

227. *Id.*

228. *Id.*

evidence of the statute's unconstitutionality, the court noted that the state legislature had recently removed all references to midwives in a statute defining medical practices.²²⁹ This action could have bolstered an individual's conclusion that midwifery is not considered to be a medical practice.²³⁰

Another midwifery victory arose in *Leggett v. Tennessee Board of Nursing*,²³¹ in which the court contemplated whether the Board of Nursing had jurisdiction over a licensed nurse when she was rendering services as a lay midwife.²³² The court noted that the Tennessee Legislature had failed to include the "care of women during pregnancy" in the statutory definition of "practicing medicine."²³³ Because of this technical deficiency, the court held that midwifery practices were outside of the board's jurisdiction.²³⁴ The court held that the board could only punish a nurse if he or she performed acts which could only be accomplished with a nursing license, such as dispensing prescription medication.²³⁵

Void-for-vagueness is not always a successful avenue for midwife challengers, however.²³⁶ In *Bowland*, the plaintiffs argued that the statutory language, which barred the unlicensed practice of medicine, could be construed so broadly as to forbid innocuous conduct such as a library loaning out medical textbooks or advising a friend to drink orange juice for a cold.²³⁷ The court dismissed this argument, finding instead that the Tennessee Legislature obviously intended to apply the statute to people

229. *Id.*

230. *Id.*

231. 612 S.W.2d 476 (Tenn. Ct. App. 1980).

232. *Leggett*, 612 S.W.2d at 479.

233. *Id.*

234. *Id.* at 481.

235. *Id.* However, the court concluded its analysis by noting that midwives could be properly penalized by a tribunal under the laws applicable to all people within the state. *Id.* This outcome reflects how a lay midwife may be charged in a state like North Dakota which allows the practice by statutory and judicial interpretation; since lay midwives are outside the scope of nursing, any punishment would be levied by the courts and not the administrative boards in charge of regulating medical professionals. *See generally* Hermer, *supra* note 11, at 355-56 ("A [lay midwife] in that state, on the other hand, is her own mistress . . . again, with the significant proviso that, should she need to intervene in a birth in order to avert disaster, she may be subject to prosecution.").

236. *See, e.g.,* *Bowland v. Mun. Court for Santa Cruz County Judicial Dist.*, 556 P.2d 1081, 1087 (Cal. 1976) (holding that the unlicensed practice of medicine was obviously limited to the practice of "healing arts"); *State ex rel. Mo. State Bd. of Registration for Healing Arts v. Southworth*, 704 S.W.2d 219, 223-24 (Mo. 1986) (holding that people of common intelligence could understand the phrases "practice of medicine" and "practice of midwifery").

237. *Bowland*, 556 P.2d at 1087.

purporting to practice the “healing arts,” under which the statute specifically included the practice of midwifery.²³⁸

The court in *State ex rel. Missouri State Board of Registration for Healing Arts v. Southworth*²³⁹ was even more direct in its analysis.²⁴⁰ The outcome specifically stated that the question of vagueness hinged upon whether the phrases “practice of medicine” and “engage in the practice of midwifery” were terms of common understanding.²⁴¹ Dismissing the challenge, the court noted that people of common intelligence could easily understand these concepts.²⁴² Specifically, the court pointed to the appellant’s testimony in which she had personally testified as to the definition of a midwife.²⁴³

When the practice of midwifery is left unregulated, or allowed by leaving the legal status of the profession undetermined, midwives are left susceptible to prosecution.²⁴⁴ Furthermore, midwives have not had much success in defending themselves by attacking midwifery regulatory schemes.²⁴⁵ However, by embracing some form of regulation that is fair to the profession, midwives can be assured of protection in their practice, while simultaneously alleviating any concerns about the welfare of those they care for.²⁴⁶

IV. THE STATUS OF MIDWIFERY LAW IN NORTH DAKOTA

With midwifery law in a constant state of flux and evolution in the United States—and North Dakota’s recent flirtation with its own set of regulations—it is certain that the state has not yet reached its final impasse with the issue.²⁴⁷ When it does resurface, it should be taken seriously, as no progress will come from turning a blind eye to the issue and leaving midwifery supporters and the medical establishment pitted against each

238. *Id.* As to the notion that friendly chit-chat could be included under the provisions, the court pointed to the statutory exemption for “family remedies,” which would include recommending vitamins, the offer of a “soothing massage,” or the presence of a husband during childbirth. *Id.*

239. 704 S.W.2d 219 (Mo. 1986).

240. *Southworth*, 704 S.W.2d at 223.

241. *Id.*

242. *Id.* at 223-24.

243. *Id.*

244. Hermer, *supra* note 11, at 355-56.

245. See Cohen, *supra* note 140, at 852-53 n.11 (discussing midwives’ failed challenges to restrictive midwifery laws).

246. See discussion *infra* Part IV (discussing the history of Senate Bill 2377 and proposing common sense legislation for the regulation of midwives in North Dakota).

247. See *supra* notes 20-22 and accompanying text (discussing the importance of midwifery in North Dakota and the increasing presence of midwives in the legal system).

other.²⁴⁸ By reviewing Senate Bill 2377, which was introduced in the 2007 legislative session, and examining the common issues that arise in midwifery law, it is possible to set out a course by which lawmakers in North Dakota may pass legislation that ensures the safety of mothers and their children, while remaining fair to the midwives who assist them during childbirth.²⁴⁹ Achieving equitable regulations may be done by imposing fair entry requirements, either by eliminating physician supervision requirements or tailoring them to promote a cooperative environment, and giving midwives a say in how the profession is regulated.²⁵⁰

A. SENATE BILL 2377 — NORTH DAKOTA’S FIRST ATTEMPT AT MIDWIFERY LEGISLATION

Senator Judy Lee introduced Senate Bill 2377 out of concern about untrained individuals practicing as midwives within North Dakota.²⁵¹ Senator Lee assured the on-looking legislators and concerned citizens that, “this doesn’t mean that somebody can’t choose to make a home birth delivery, but it does mean that people who call themselves midwives need to be trained professionally.”²⁵² As introduced, however, the legislation would have effectively added North Dakota to the list of states that prohibit lay midwifery outright.²⁵³

The bill itself opened with a bang by amending the state’s criminal code to make it a class B misdemeanor for a person to provide obstetrical services to an individual unless that person is licensed as either a registered nurse or physician under North Dakota law.²⁵⁴ A violation of the provisions could be prosecuted as either the unauthorized practice of medicine or the unauthorized practice of nursing.²⁵⁵ The bill defined “obstetrical services” as “the physical examination of an individual at any stage of her pregnancy and . . . the physical supervision or provision of services to an

248. Wolfson, *supra* note 21, at 956.

249. See discussion *infra* Parts IV.A-B (summarizing the hearings on and provisions of Senate Bill 2377 and proposing common sense legislation for midwives in North Dakota).

250. See discussion *infra* Part IV.B.1-3 (detailing provisions for midwifery legislation).

251. Senate Committee Hearings, *supra* note 3, at 1 (statement of Sen. Judy Lee, Chairwoman, S. Comm. on Human Serv.).

252. *Id.*

253. Gwen Bristol, *Bill Could Make Lay Midwifery Illegal in N.D.*, MINOT DAILY NEWS, Feb. 8, 2007, at B1.

254. S. 2377, 2007 Leg., 60th Sess. (N.D. 2007). See N.D. CENT. CODE § 43-12.1-09 (2007) (requiring that nurses successfully complete a nursing education program, pass an examination, and present a completed application and fees); *id.* § 43-17-18 (requiring that a physician graduate from a medical school, successfully complete a licensing examination, and present an application attesting to the “good moral character” of the applicant).

255. S. 2377, 2007 Leg., 60th Sess. (N.D. 2007).

individual during her labor or childbirth.”²⁵⁶ Through this definition, the proposed statute essentially required that a woman seeking a home birth find either a doctor or registered nurse to perform house calls not only during labor, but in the preceding months as well.²⁵⁷ However, the bill also included an exemption for family members who were not providing services as a “business arrangement,” and a Good Samaritan Clause for both lay people and medical services operators assisting in emergency situations.²⁵⁸

While considering this legislation, the Senate Human Services Committee received impassioned testimony related to the bill, with opponents—generally mothers and fathers who had utilized lay midwives during home births—arguing that birth is not a disease, but a “natural process a woman’s body was made to do all on its own.”²⁵⁹ Meanwhile, bill supporters—generally professionals from the medical community—stressed the mantra of patient safety.²⁶⁰ After extensive deliberation, the committee agreed on the general merits of midwives and opined that better legislation could be drafted to actually assist them in their practice.²⁶¹ The committee amended the bill into a resolution directing the Legislative Council to study midwifery law and determine whether current law already addressed the problem.²⁶²

Senator Joan Heckaman, a cosponsor of the original legislation, introduced the amended Senate Bill 2377 to the House Human Services Committee on March 12, 2007.²⁶³ She testified that she supported the changes to the bill because of her concern for women in rural areas of the state who rely on midwives, and her belief that midwifery would continue

256. *Id.*

257. *Id.*

258. *Id.* North Dakota has a general Good Samaritan Act, which gives immunity to an individual who renders aid to the injured or ill, unless the acts constitute intentional misconduct or gross negligence. N.D. CENT. CODE § 32-03.1 (2007). There is also a specific provision in the code bestowing the same protection—and exceptions—to licensed physicians performing emergency obstetrical care to a “pregnant female in active labor.” *Id.* § 32-03.1-02.1. However, this immunity is waived should the physician either collect a fee or perform the act with the expectation of remuneration. *Id.*

259. Senate Committee Hearings, *supra* note 3, at 4 (testimony of Becky Olsen).

260. *Id.* at 3 (testimony of Wanda Rose, Vice President, North Dakota Nurses Association). Dr. Rafael Ocejo, a Bismarck pediatrician and neonatologist, quickly conceded that childbirth is “one of the most natural processes on earth,” but stressed that birthing results “can vary from disaster to amazingly good outcomes, depending on where and how a baby is delivered.” *Id.* at 2 (testimony of Dr. Rafael Ocejo).

261. *Id.* at 9-10.

262. Engrossed S. 2377, 2007 Leg., 60th Sess. (N.D. 2007).

263. House Committee Hearings, *supra* note 6, at 1 (testimony of Sen. Joan Heckaman).

to be “an important part of our state.”²⁶⁴ The House Committee heard testimony from many of the same individuals heard by their Senate counterparts, even retracting statements from some midwifery supporters that they would not be opposed to a form of regulation on lay midwives in the state.²⁶⁵ However, several midwifery supporters testified against the study, citing concerns ranging from an opposition to regulations as a whole, to the belief that the Legislative Council would conduct an “unfair” study that failed to factor in “certain considerations” supportive of lay midwives.²⁶⁶

In the end, the House Committee recommended a Do Not Pass on the bill, believing that, “[b]y studying [midwifery] you are only endorsing the idea of putting . . . further restrictions” on the practice.²⁶⁷ The full House of Representatives followed the House Committee’s lead and defeated the bill in a near unanimous vote.²⁶⁸ By doing so, the legislature opted to maintain the status quo, leaving the scope of practice undefined, with no assurances that midwives are qualified to assist in childbirth, and no protection for midwives should something go wrong during a delivery.²⁶⁹

B. A “FRIENDLY” APPROACH: COMMON SENSE REGULATIONS FOR LAY MIDWIVES IN NORTH DAKOTA

The North Dakota Legislature opted against midwifery regulations in part because it believed that midwifery was not a large enough problem in the state to warrant legislation.²⁷⁰ However, the legislature need not wait

264. *Id.* Senator Heckaman proved a frequent critic of the bill’s original language throughout the Senate hearings as well, stating that she would prefer to turn the legislation around and “do something positive in this area instead of penalizing people.” Senate Committee Hearings, *supra* note 3, at 10. See David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 MARQ. L. REV. 975, 1009 (1992) (stating that where midwifery is overregulated or prohibited, rural women are often left with no prenatal or birthing care within a reasonable distance of their homes).

265. See House Committee Hearings, *supra* note 6, at 2-3 (testimony of Becky Olsen) (stating that some form of registry or regulation would have a positive effect in the state).

266. See *id.* at 12-13 (testimony of Donna Henderson) (arguing that regulations would prevent people from having safe home births who had previously experienced complications during hospital births); *id.* at 13 (testimony of Summer Joy Peterson) (arguing against a study on the grounds that it would only promote the idea of regulations); *id.* at 2 (statement of Patrick Hatlestad) (“What I have heard from people about the concern of the study is the fact that the medical community will shake the direction [of the study].”).

267. *Id.* at 1 (statement of Jasper Schneider).

268. *H. Journal*, 2007 Leg., 60th Sess., at 1147 (N.D. 2007), available at <http://www.legis.nd.gov/assembly/60-2007/journals/hr57.pdf#Page1147>.

269. Hermer, *supra* note 11, at 355. See DEVRIES, *supra* note 3, at 120 (“[I]n the absence of licensing laws, legal action becomes the only method for the regulation of midwives.” (citing Laura King, *Midwives’ Uneasy Truce in Jeopardy*, CONTRA COSTA TIMES, July 10, 1981, at 4A)).

270. House Committee Hearings, *supra* note 6, at 1 (statement of Curt Hofstad).

for a pandemic or the death of a newborn before it takes action.²⁷¹ The law does not exist solely as a reactionary entity, but as a proactive force for good.²⁷² To that end, midwives should embrace a common sense form of legislation, as the affordance of a legal status brings with it privileges and benefits to the profession.²⁷³ Such benefits include a sense of public legitimacy, alleviating the fears of legal action, and an improved business model by which midwives may advertise and perform their functions in the open.²⁷⁴

Historically, scholars have drawn a distinction between “friendly” and “hostile” licensure, which are defined by the individuals who control the licensing process.²⁷⁵ However, these basic concepts may be applied to midwifery regulations in general so that the North Dakota Legislature can draft laws that make sure the profession is properly regulated, but also give “friendly” deference to those midwives whom the law is overseeing. This approach can be helpful when dealing with the basic topics that arise out of midwifery regulations, including entry requirements, physician supervision provisions, and the make-up of regulatory boards.²⁷⁶

1. *Entry Requirements*

The first step in constructing friendly midwifery legislation is to ensure that entry requirements are both adequate and appropriate.²⁷⁷ Lay midwives have traditionally received training through a combination of self-education and apprenticeship, which allows them to “sustain a naturalistic,

271. See generally Julia Solo, *Urban Decay and the Role of Superfund: Legal Barriers to Redevelopment and Prospects for Change*, 43 BUFF. L. REV. 285, 327 (1995) (“The problem with reactive legislation . . . is that it attempts to solve one problem while creating a host of others. A move toward proactive legislation is essential if we hope to avoid the unintended effects of hastily passed legislation in the future.”).

272. *Id.*

273. See DEVRIES, *supra* note 3, at 30 (noting that many midwives openly embrace licensure, believing that such legislation will help insure their professional future).

274. *Id.* at 117. See Anderson & Anderson, *supra* note 85, at 30 (stating that the relatively low number of home births in the United States may be a by-product of more successful advertising by hospitals).

275. DEVRIES, *supra* note 3, at 29. In the context of midwifery, “friendly” licensure would be controlled by a board of individuals who are themselves lay midwives; “hostile” licensure would place midwives under “outside control,” such as nursing or medical boards. See generally *id.* (explaining the difference between “friendly” and “hostile” licensure).

276. See discussion *infra* notes 277-311 and accompanying text (recommending provisions on these issues which would be fair to midwives, while taking into consideration safety issues pertaining to mothers and children).

277. See Corcoran, *supra* note 17, at 669-70 (“[E]ntry requirements for direct-entry midwives can both protect the public and accommodate the unique skills and knowledge of direct-entry midwives.”); see also Reilley, *supra* note 120, at 1142 (stating that the ultimate goal in constructing reasonable midwifery restrictions is to make sure that midwives remain a safe alternative to physicians).

noninterventionist view of birth.”²⁷⁸ Because this philosophy is at the core of the lay midwifery outlook, entry requirements which rely exclusively on formal education have been attacked as “inappropriate.”²⁷⁹ While a standard is necessary to ensure the safety of childbirth, any entry requirements placed upon midwives must be tempered to ensure that the heart of lay midwifery is not ripped from the profession’s ribcage.²⁸⁰

An appropriate approach to entry requirements would be to require the successful completion of the national certification standards prescribed by NARM.²⁸¹ To meet these standards, midwives must pass a written examination and either complete an accredited program, or show that they possess the equivalent knowledge and skills that would be gained through more formalized training.²⁸² Upon completion of the certification process, a midwife is entitled to use the title “Certified Professional Midwife” in his or her practice.²⁸³ By putting the focus on knowledge and skills, rather than the method by which a midwife has acquired them, assurances of safety and competency may be met without requiring additional education unless the midwife needs it to comport with the standard of care.²⁸⁴

States that provide for no training requirements endanger the public’s safety by potentially allowing incapable people to practice midwifery.²⁸⁵ At the same time, such requirements should be reasonable in order to allow qualified individuals into the profession.²⁸⁶ However, such entry requirements may still prove irrelevant if midwives will later be burdened with thorny physician supervision requirements.²⁸⁷

278. DEVRIES, *supra* note 3, at 92.

279. Corcoran, *supra* note 17, at 670. See Jo Anne Myers-Ciecko, *Evolution and Current Status of Direct-Entry Midwifery Education, Regulation, and Practice in the United States, With Examples from Washington State*, 44 J. NURSE-MIDWIFERY 384, 386 (1999) (noting that an independent review of midwifery entry requirements found that a skills-based formula was the “best practice”).

280. See discussion *infra* notes 281-87 (describing such balanced entry requirements).

281. Corcoran, *supra* note 17, at 670.

282. The North American Registry of Midwives, *The Certified Professional Midwife* (1998) [hereinafter NARM Standards]. See Myers-Ciecko, *supra* note 279, at 389-90 (describing NARM entry-to-practice standards).

283. Myers-Ciecko, *supra* note 279, at 386.

284. Corcoran, *supra* note 17, at 670. Furthermore, under a system of this nature, a midwife who has not gone through a formal education, and whose knowledge and skills lack in certain key areas, could be required to undergo education in only those subjects, rather than completing an entire curriculum. See CAL. BUS. & PROF. § 2512.5(a)(3)(A)-(H) (2007) (listing examples of which subjects a midwife may need to have baseline knowledge and skills).

285. Reilly, *supra* note 120, at 1143.

286. Corcoran, *supra* note 17, at 670.

287. See Myers-Ciecko, *supra* note 279, at 389 (noting that physician supervision requirements are often difficult to fulfill, thus making it difficult for midwives to lawfully practice).

2. *Physician Supervision*

Provisions requiring physicians to supervise midwives are the most contentious aspects of the regulatory debate and have been imposed on both lay and nurse-midwives.²⁸⁸ In many instances, midwives find it difficult to locate physicians who are willing to supervise them.²⁸⁹ In the instances when they do find a supervising physician, many states leave the definition of “supervision” ambiguous.²⁹⁰ As a result, a physician who objects to midwifery may impose stricter requirements than necessary.²⁹¹

Due to the possibility of the misuse of physician supervision and the heavy burden of finding a physician willing to enter into a supervisory relationship, legislation could be drawn up that would eliminate supervision requirements entirely.²⁹² However, to maintain the highest degree of safety and care, a substitute provision could be implemented under which midwives would enter into a “collaborative” relationship with physicians.²⁹³ In this type of relationship, midwives would simply have a working relationship with a physician with whom they might confer or refer complicated cases.²⁹⁴ Such a provision could either be mandatory or made optional and offered to midwives under some form of incentive program.²⁹⁵

288. See Hermer, *supra* note 11, at 349, 353 (discussing the supervision requirements on nurse-midwives and lay midwives).

289. DEVRIES, *supra* note 3, at 115. See Tovino, *supra* note 15, at 95 (noting that in California, where lay midwives are required to have physician supervision, such support is so rarely forthcoming that in 2001 only one of 111 licensed midwives actually obtained a supervising physician).

290. Hermer, *supra* note 11, at 349-50.

291. See *id.* (noting that ambiguous statutory language allows physicians to impose unreasonable medical requirements and oversight on midwives).

292. See Sara K. Hayden, *The Business of Birth: Obstacles Facing Low-Income Women in Choosing Midwifery Care After the Licensed Midwifery Practice Act of 1993*, 19 BERKELEY WOMEN'S L.J. 257, 262 (2004) (discussing the difficulty in finding physicians willing to supervise midwives); Myers-Ciecko, *supra* note 279, at 389-90 (recommending that laws be created which do not require midwives to be directed or supervised by other health care practitioners).

293. Hermer, *supra* note 11, at 349.

294. *Id.*

295. See generally Myers-Ciecko, *supra* note 279, at 389 (noting that physicians and midwives should find a way to have effective consultative or collaborative relationships). Any mandatory “physician collaboration” provision would have to take into account the pervasive hesitation on the part of physicians to enter into relationships with midwives. See Hermer, *supra* note 11, at 349-50 (discussing the difficulty of midwives in finding physician assistance). Under such a system, physicians should be required by the state board of health to enter into such relationships, which would ensure that midwives could lawfully practice in the state. See generally Tovino, *supra* note 15, at 104 (noting that in California, when a midwife is unable to find a physician who will provide supervision, he or she cannot legally practice). Under an optional program, a midwife who elects to enter into a collaborative relationship with a physician might opt out of certain educational entry requirements for licensure in the state. This would have the same effect as the NARM standards, which give midwives the option of completing an

Some midwifery supporters view the physician supervision requirement as a means for the medical establishment to belittle midwives' training and expertise.²⁹⁶ It is important for these provisions to be either banished from statutory regulations, or drawn up in a manner that would ensure that midwives retain some control over their occupation.²⁹⁷ However, for midwives to truly have a hand in their own destinies, it would also be necessary for them to have a functioning role in overseeing the profession at large.²⁹⁸

3. *Boards Overseeing Lay Midwives*

Historically, commentators have stressed that the weakness of midwifery as a profession stemmed in part from placing the oversight of the profession into the hands of medical and nursing boards, rather than in a board of midwife examiners.²⁹⁹ It seems unlikely that a state would adopt provisions to create a board that would vest all control over the profession into the hands of midwives.³⁰⁰ However, the trend among states that license midwives has been to establish subsidiary boards, which include midwives in their membership, to assist in regulating the profession.³⁰¹

Texas has such a two-tiered system in which a “Midwifery Board” adopts procedures and reports to the Texas Department of Health on matters involving midwifery within the state.³⁰² The Midwifery Board is made up of three midwives with at least three years of experience, one certified nurse-midwife, one physician certified in obstetrics and gynecology, one physician certified as a pediatrician, and three members of the public—one of whom is a parent with at least one child born with the assistance of a

educational program, or obtaining proficiency through training. *See generally* NARM Standards, *supra* note 282 (detailing the NARM standards).

296. Tovino, *supra* note 15, at 104.

297. *See supra* notes 288-95 and accompanying text (detailing the delicate nature of physician supervision requirements and how they can be fashioned to be fair to lay midwives).

298. Reilley, *supra* note 120, at 1144 (noting that by self-policing the profession, midwives would have an enhanced interest in its success, and could ensure the quality of their services).

299. DEVRIES, *supra* note 3, at 29. *See* Reilley, *supra* note 120, at 1144 (discussing medical boards which inhibited the growth of the midwifery profession).

300. *See* DEVRIES, *supra* note 3, at 29 (stating that, in the past, the licensing of midwives has been notoriously “hostile” in nature).

301. *See, e.g.*, 007-13 ARK. CODE R. § 102 (2007) (establishing an Advisory Board to meet at least annually and at the discretion of its chairperson to review midwifery rules and regulations and propose changes as needed); S.C. CODE ANN. REGS. § 61-24(Q) (2007) (stating that the Department of Health shall appoint a Midwifery Advisory Council to assist the department in matters pertaining to midwifery training, practices, and regulation); VA. CODE ANN. § 54.1-2957.10 (2007) (establishing an Advisory Board on Midwifery to assist the Board of Medicine in formulating midwifery regulations); WASH. REV. CODE § 18.50.140 (2007) (creating the Midwifery Advisory Committee whose members are appointed by the Secretary of Health).

302. TEX. OCC. CODE ANN. § 203.051 (Vernon 2007).

midwife.³⁰³ This board is responsible for adopting proposed rules regarding the standard of practice, documentation of midwives, educational requirements, the reporting and investigating of complaints, and disciplinary actions.³⁰⁴ The Texas Department of Health and its own internal board then act upon these recommendations by implementing official rules for the profession.³⁰⁵

Florida implemented a similar system by statute when it established the Council of Licensed Midwifery, which reports to the state's Department of Health.³⁰⁶ The council acts in an advisory role to the department by developing rules relating to training requirements, fees, informed consent forms, emergency plans, records and reports, and the state licensing examination.³⁰⁷ However, the statute specifically allots other functions to the council, including monitoring lay midwifery in other states and countries, educating the public and medical community on midwifery, and recommending future changes to midwifery law within the state.³⁰⁸

Midwives have long been concerned that restrictive licensing regulations could change the relationships they enjoy with their clients, transforming these relationships into more formal, medical entities.³⁰⁹ Including midwives in key advisory board positions can provide a balanced approach to regulations that are both "sufficiently dynamic and holistic."³¹⁰ More importantly, by giving midwives a role in the decision-making process, North Dakota can ensure that midwives' voices are heard, and that the profession remains tailored to the "naturalistic, noninterventionist" principles upon which it is based.³¹¹

303. *Id.* § 203.052.

304. *Id.* § 203.151(a)(1)-(6).

305. *Id.* § 203.156.

306. FLA. STAT. § 467.004 (2007). The Council of Licensed Midwifery is composed of: three physicians, one nurse-midwife, three licensed midwives, and one independent state resident. *Id.* § 467.004(2).

307. *Id.* § 467.004(3)(a).

308. *Id.* § 467.004(3).

309. *See* DEVRIES, *supra* note 3, at 110 (discussing concerns of midwives over the effects of regulations).

310. *See* Recent Legislation, *Health Care Law—"Drive Through Delivery" Regulation—Massachusetts Requires Hospital Stays of Forty-Eight Hours for Newborns and Postpartum Mothers—Act of Nov. 21, 1995, ch. 218 §§ 1-10, 1995 Mass. Legis. Serv. 726, 726-28 (West)*, 109 HARV. L. REV. 2116, 2120 (1996) (discussing the advantages of balanced midwifery regulations).

311. *See* DEVRIES, *supra* note 3, at 92 (discussing the naturalistic approach and philosophy of midwives); *see also* Hermer, *supra* note 11, at 334 (discussing the criticisms of nurse-midwives, whose ties to the medical community are seen as moving the profession away from its natural-oriented nexus).

V. CONCLUSION

Lay midwives in North Dakota are wedged into an intriguingly tenuous position.³¹² On the one hand, they are technically allowed to practice their wares, free from regulation and oversight.³¹³ On the other hand, they are operating in a vague legal climate, leaving them susceptible to charges of unlawfully practicing medicine for stepping anywhere near the boundaries of what constitutes a medical procedure.³¹⁴ Likewise, North Dakota mothers who choose home births currently have unfettered access to lay midwives.³¹⁵ However, with no board or body regulating the profession, these mothers also run the risk of placing their welfare—and that of their children—in the hands of someone who lacks the necessary training or competency.³¹⁶

With thirty-six states either permitting or prohibiting lay midwifery by statute, the clear trend across the country is to regulate the profession.³¹⁷ North Dakota nearly jumped into this fray with Senate Bill 2377, which, by restricting all forms of obstetrics to either registered nurses or physicians, would have essentially prohibited lay midwives from assisting in childbirth.³¹⁸ Instead, the North Dakota Legislature opted to pass no law at all, becoming entangled in its concerns over protecting the health and safety of its mothers and newborns, while securing the practice of lay midwifery in the state.³¹⁹ To appease both of these concerns, the Legislature should pass friendly, commonsense legislation that strikes a middle ground between the

312. *See generally* Hermer, *supra* note 11, at 355 (discussing statutory-interpretation states, like North Dakota, where midwives walk a tightrope between the freedom to practice and the fear of prosecution).

313. *See id.* (stating that in North Dakota and other “statutory interpretation” states, midwives may practice without state regulation).

314. *See id.* (discussing the risk of prosecution faced by midwives in “statutory interpretation” states).

315. *See* DEVRIES, *supra* note 3, at 101 (stating that licensure may reduce the number of births with midwife-assistance, due to stricter limits on the definition of “normal childbirth,” mandated education, and increased surveillance over the practice).

316. *See* Senate Committee Hearings, *supra* note 3, at 1 (testimony of Sen. Judy Lee, Chairwoman, S. Comm. on Human Serv.) (discussing the concern over untrained individuals performing services as midwives); *id.* at 1-2 (testimony of Bruce Levi, N.D. Med. Ass’n) (stating that anyone who provides obstetrical services should be competent to do so).

317. MANA Chart, *supra* note 102.

318. *See* S. 2377, 2007 Leg., 60th Sess. (N.D. 2007) (requiring a medical license to practice midwifery); Bristol, *supra* note 253, at B1 (discussing the potential impact of S. 2377 on lay midwives in North Dakota).

319. *See* Senate Committee Hearings, *supra* note 3, at 1 (testimony of Senator Judy Lee, Chairwoman, S. Comm. on Human Serv.) (discussing concerns over untrained midwives endangering women and infants); House Committee Hearings, *supra* note 6, at 1 (testimony of Sen. Joan Heckaman) (expressing a desire to maintain midwifery presence in North Dakota).

interests of all involved.³²⁰ Such a balance may be fashioned by (1) imposing skill and knowledge-based requirements upon midwives;³²¹ (2) eliminating the need for physician supervision, or replacing it with a more collegial, collaborative relationship;³²² and (3) giving midwives a voice in the regulatory process.³²³

In November 2006, Lynette Johnson of Tuttle, North Dakota prepared for her first home birth with a midwife, expecting to bring her third child into the world.³²⁴ However, after one child was born, her midwife realized that she was not done giving birth and Ms. Johnson ended up delivering triplets in her bedroom.³²⁵ Had she known earlier that she was pregnant with triplets, she would have likely had a caesarean section, and the children would have been placed in a hospital's intensive care unit.³²⁶ However, she was happy that she was able to bring them into the world at home and stated that she would use a midwife for a home birth again.³²⁷ It was Ms. Johnson's unique birth experience that initially prompted the creation of Senate Bill 2377.³²⁸ It is up to the North Dakota Legislature to make sure that mothers like Ms. Johnson can continue to have home births, and can have them as safely as possible.

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320. See discussion *supra* Part III.C (suggesting legislation which would impose reasonable regulations on the profession).

321. See Corcoran, *supra* note 17, at 670 (noting that entry requirements which focus on skill and knowledge will net the same benefits as examining formal education, and will encourage more lay midwives to enter the profession).

322. See Hermer, *supra* note 11, at 349-50 (describing the arduousness of physician supervision requirements, and the more beneficial collaborative relationships).

323. See discussion *supra* notes 299-311 and accompanying text (discussing the benefits of establishing midwife-friendly regulatory boards).

324. Sara Kincaid, *It Touches Our Hearts*, BISMARCK TRIB., Jan. 15, 2007, at A1.

325. *Id.*

326. *Id.*

327. *Id.*

328. Senate Committee Hearings, *supra* note 3, at 9.

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