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Midwives and Home Birth: Social, Medical, and Legal Perspectives

By CHARLES WOLFSON*

Art thou sick? If thou art, thou must consent to receive the best treatment which the times will afford. These men will convey thee to the hospital at Bush-Hill.

The mention of that contagious and abhorred receptacle, inspired me with some degree of energy

. . . .

. . . I knew in what manner patients were treated at the hospital, and removal thither was to the last degree abhorred.

*Charles Brockden Brown*¹

There will be a midwife problem as long as there is a midwife, and there will be midwives as long as there is an element of ignorance and superstition in the population.

*M. P. Rucker*²

A trend against the medicalization³ of birth began in the 1970s, sparking a clamorous debate among various lay, medical, legislative, and legal factions. The debate focuses on obstetric practices, home birth,⁴

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1. 2 C. BROWN, ARTHUR MERVYN 141-42, 164 (ed. New York 1962) (1st ed. n.p. 1799).

2. M. Rucker, *The Relation of the Midwife to Obstetric Mortality with Special Consideration to New Jersey*.

3. The "medicalization" of birth refers to three distinct phenomena: first, the elimination of the midwife as a primary birth attendant, see, e.g., Devitt, *How Doctors Conspired to Eliminate the Midwife Even Though the Scientific Data Supports Midwifery*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 345 (D. Stewart & L. Stewart eds. 1979); Kobrin, *The American Midwife Controversy: A Crisis of Professionalization*, 40 BULL. HIST. MED. 350 (1966); second, the shift in the location of birth from home to hospital, see, e.g., Devitt, *The Transition from Home to Hospital Birth in the United States, 1930-1960*, BIRTH & FAM. J., Summer 1977, at 47 (percentage of hospital births rose from 39.6% in 1935 to 96% in 1960); and third, the use of increasingly invasive medical interventions during the birth process, see, e.g., S. ARMS, IMMACULATE DECEPTION 62-123 (1975); Ratner, *The History of the Dehumanization of American Obstetrical Practice*, in 1 21ST CENTURY OBSTETRICS NOW! 115, 126-40 (L. Stewart & D. Stewart eds. 1977). See generally R. WERTZ & D. WERTZ, LYING-IN, A HISTORY OF CHILDBIRTH IN AMERICA (1977).

4. The American College of Obstetricians and Gynecologists categorically opposes

and midwifery,⁵ and concerns society's most precious and vulnerable members—its newborn children. Adults generally have the right to make their own decisions regarding medical treatment.⁶ With childbirth, however, medical choices made by the adult affect the unborn child as well. The dual impact of such decisions complicates the surrounding legal and moral issues.⁷ Different constituencies, including parents, doctors, and the state, all arguing from different perspectives, each claim the authority to resolve these issues in the manner they deem best.

This Article attempts to reconcile the various interests implicated in this controversy. The Article first considers the relative safety of hospital and home births, addressing both medical and social perspectives. The Article next examines the present state of the law concerning midwifery and home birth. It then addresses the problem of prioritizing the rights and obligations of the constituencies engaged in making decisions concerning childbirth. Finally, the Article proposes a model statute that ac-

home birth. See Aubry, *The American College of Obstetricians and Gynecologists: Standards for Safe Childbearing*, in 1 21ST CENTURY OBSTETRICS NOW! 15, 15-26 (L. Stewart & D. Stewart eds. 1977). In contrast, the American College of Nurse-Midwives does not oppose home birth, although it has adopted no official position toward lay midwives. See, e.g., Baxter, *Cooperation or Competition? The Choice is Ours*, J. NURSE-MIDWIFERY, Nov.-Dec. 1981, at 1; Hsia, *A Time for Waiting*, J. NURSE-MIDWIFERY, Fall 1978, at 5; Shah, *The Unification of Midwives: A Time for Dialogue*, J. NURSE-MIDWIFERY, Sept.-Oct. 1982, at 1.

5. This Article focuses primarily on lay midwives. There are two basic categories of midwives: certified nurse-midwives and lay midwives. Certified nurse-midwives ("CNM's") are registered nurses who have completed a graduate course of study in a program accredited by the American College of Nurse-Midwives. For a comparative perspective on nurse-midwives, see Note, *Childbearing and Nurse-Midwives: A Woman's Right to Choose*, 58 N.Y.U. L. REV. 661 (1983). Lay midwives, sometimes called empirical midwives, may, but usually do not, come from a nursing background. Their training is generally self-acquired, although formal education programs are becoming more common as states pass laws permitting licensing. See, e.g., P. SALLOMI, A. PALLO-FLEURY & P. MCMAHON, *MIDWIFERY AND THE LAW* 33-35 (1982) [hereinafter cited as P. SALLOMI]. Although lay midwives and certified nurse-midwives share many of the same values and practice characteristics, some women prefer lay midwives because of their nonmedical orientation. See Baxter, *supra* note 4, at 1-2.

6. See *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914); Note, *Family Law—Court-Ordered Surgery for the Protection of a Viable Fetus—Jefferson v. Griffin Spalding County Hospital Authority*, 5 W. NEW ENG. L. REV. 125, 126-27 (1982). Nevertheless, faced with an intransigent adult who refuses life-saving treatment, the courts will often attempt to justify ordering medical treatment by defining as legal incompetence that which they perceive as irrationality. See, e.g., *Lane v. Candura*, 6 Mass. App. Ct. 377, 379-80, 383-85, 376 N.E.2d 1232, 1233-36 (1978); Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337, 341-42 (1978).

7. For discussion elsewhere in this symposium of another aspect of the issue of medical choices by adults that affect the unborn child as well, see Nelson, Buggy & Weil, *Forced Treatment of Pregnant Women: "Compelling Each to Live as Seems Good to the Rest"*, 37 HASTINGS L.J. 703 (1986) [hereinafter cited as Nelson].

knowledges, supports, and regulates home birth and lay midwives, thus providing parents with a safe and viable alternative to hospital birth.

Safety in Childbirth: Medical Versus Social Risk Assessment

Home Birth

Figures from the National Center for Health Statistics indicate that from 1976 to 1979 the percentage of home births occurring in the United States leveled off at approximately one percent of all births.⁸ For various reasons, these statistics may be misleading. First, a significant number of home births probably go unreported.⁹ Second, the number of freestanding birth centers ("FBC's")¹⁰ grew from three in 1975 to 130 in 1982, and FBC births are treated as hospital births in these figures.¹¹ Third, although home births have decreased in some areas,¹² they have increased in many others,¹³ and nationwide figures mask these potentially

8. See S. TAFTEL, MIDWIFE AND OUT-OF-HOSPITAL DELIVERIES: UNITED STATES 4 (Nat'l Center for Health Statistics, U.S. Dep't of Health & Human Servs., Vital Health Statistics Series 21, No. 40, 1984); Pearse, *Trends in Out-of-Hospital Births*, 60 OBSTETRICS & GYN-ECOLOGY 267, 270 (1982).

9. See Mehl, Ramiel, Leininger, Hoff, Kronenthal & Peterson, *Evaluation of Outcomes of Non-Nurse Midwives: Matched Comparisons with Physicians*, WOMEN & HEALTH, Summer 1980, at 17, 19 [hereinafter cited as Mehl, *Comparisons*]; Stocking, *The Rebirth of Home Birth*, Detroit News, Feb. 12, 1984 (Magazine), at 12-13.

10. FBC's are small non-hospital maternity facilities generally operated by midwives. See, e.g., Vogler, *Delta Maternity Center*, MOTHERING, Spring 1983, at 76.

11. See COMMITTEE ON ASSESSING ALTERNATIVE BIRTH SETTINGS, RESEARCH ISSUES IN THE ASSESSMENT OF BIRTH SETTINGS 17 (1982) [hereinafter cited as COMMITTEE REPORT].

Oregon is one of the few states whose statistics differentiate between home, FBC, and hospital births. In 1976, of 959 out-of-hospital births in Oregon, 74% took place at home and 18% occurred in clinics. In 1977, of 1492 such births, the figures were 60% and 32%, respectively. Dingley, *Birthplace and Attendants: Oregon's Alternative Experience, 1977*, in 4 WOMEN & HEALTH 239, 243 (1979). Dingley interprets these figures as revealing "[a]n important shift in the place of birth," but the figures actually represent an absolute increase in the number of home births from 724 to 897, coupled with an even greater increase in the number of FBC births. *Id.*

12. These regional variations may be attributable to the fact that in states such as Washington and California, where attendants and support are more readily available, home birth-rates have continued to increase. See Foster, *Up Against the Birth Monopoly*, REASON, Sept. 1982, at 23, 24. Conversely, in states where professional and bureaucratic resistance is high, the number of home births has leveled off or declined. See *id.* at 28 (attempt by public health departments in southern states to eliminate "granny" midwives). But see Arkansas Nurse Midwifery Act, ARK. STAT. ANN. §§ 72-2201 to -2209 (Supp. 1985) (licensing revived because of inadequacy of medical care available to rural poor).

13. See, e.g., L. BARTON & C. HARVEY, OUT OF HOSPITAL BIRTHS IN IDAHO 1977, at 35 (1978) [hereinafter cited as L. BARTON]; Dingley, *supra* note 11, at 244-48 (Oregon); Foster, *supra* note 12, at 24 (California); Simmons & Bernstein, *Out-of-Hospital Births in Michigan, 1972-79: Trends and Implications for the Safety of Planned Home Deliveries*, 98 PUB.

significant regional fluctuations.¹⁴ In any event, it is clear that a significant number of parents today are choosing to have their children at home. This section discusses the typical characteristics of those who choose home birth, the reasons for their decision, and the advantages and disadvantages of the home birth process.

Many in the medical community dismiss as odd or unusual the types of parents who choose home birth.¹⁵ In fact, home birth has attracted parents from a wide social spectrum. For example, Hazell's oft-cited study of couples in the San Francisco Bay Area who chose home birth revealed that ninety percent "lived in stereotyped American fashion."¹⁶ Subsequent studies have persistently drawn the same composite portrait, concluding that home birth couples are generally middle class, gainfully employed, and slightly older and more educated than the norm.¹⁷

Typically, the decision to give birth at home is the result of careful and critical evaluation of the available options.¹⁸ Several basic motivations are most often cited to explain why parents forego conventional hospital deliveries. Among these are a desire to obtain greater control over the birth process, to enjoy a more relaxed environment, and to achieve financial savings.¹⁹

HEALTH REP. 161, 161 (1983) (Michigan); *Midwifery is Disputed*, N.Y. Times, July 12, 1981, § 1, at 40, col.1 (Vermont); Letter from Nancy Clarke & Anita Bennetts to the Editor, 62 OBSTETRICS & GYNECOLOGY 397 (1983) (Oregon) [hereinafter cited as Letter].

14. See Letter, *supra* note 13.

15. See Annas, *Homebirth: Autonomy vs. Safety*, HASTINGS CENTER REP., Aug. 1978, at 19; Cohen, *A Comparative Study of Women Choosing Two Different Childbirth Alternatives*, 9 BIRTH 13, 18 (1982). Others suggest that inexperienced lay teachers paint a misleadingly "rosy picture" of home birth that "propagandize[s]" inexperienced and gullible patients. Ranney, *Responsibilities, Ten Problems, and a Few Solutions*, 61 OBSTETRICS & GYNECOLOGY 241, 245 (1983).

16. Hazell, *A Study of 300 Elective Home Births*, 2 BIRTH & FAM. J. 11, 12 (1975).

17. See, e.g., *Nurse Midwifery: Consumers' Freedom of Choice: Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce*, 96th Cong., 2d Sess. 111, 115 (1980) (reprinted lecture of C. Arden Miller, M.D., Dep't of Maternal and Child Health, School of Pub. Health, Univ. of N. C.) (MCA Childbearing Center, New York City) [hereinafter cited as *Midwifery Hearings*]; L. BARTON, *supra* note 13, at 36 (Idaho); M. CONKLIN & R. SIMMONS, *PLANNED HOME CHILDBIRTHS: PARENTAL PERSPECTIVES* 11-15 (Mich. Dep't of Pub. Health Monograph No. 2, 1979) (Michigan); Bauwens & Anderson, *Home Births: A Reaction to Hospital Environmental Stressors*, in *THE ANTHROPOLOGY OF HEALTH* 56, 57 (E. Bauwens ed. 1978) (Arizona); Herman, Miller-Klein & Vantre, *A Survey of Current Trends in Home Birth*, in 3 *COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH?* 757 (D. Stewart & L. Stewart eds. 1979) (nationwide).

18. See M. CONKLIN & R. SIMMONS, *supra* note 17, at 60; Hosford, *The Home Birth Movement*, J. NURSE-MIDWIFERY, Fall 1976, at 27, 28; Lee & Glasser, *Role of Lay Midwifery in Maternity Care in a Large Metropolitan Area*, 89 PUB. HEALTH REP. 537, 543 (1974).

19. See, e.g., Anderson, Bauwens & Warner, *The Choice of Home Birth in a Metropolitan County in Arizona*, JOGNN NURSING, Mar.-Apr. 1978, at 41, 43 [hereinafter cited as Anderson]; Burnett, Jones, Rooks, Chen, Tyler & Miller, *Home Delivery and Neonatal Mortality in*

The narrow medical perspective of some obstetricians is another major reason why some parents choose to give birth at home.²⁰ Although today's obstetricians acknowledge that psychological and environmental support are worthwhile objectives, some still tend to regard such considerations as extraneous to quality medical care.²¹ Parents who choose home birth, however, argue that psychological and environmental factors directly affect the mother's physical condition and that treatment is deficient if such factors are ignored.²² These parents also object to what they

North Carolina, 244 J. A.M.A. 2741, 2741 (1980) [hereinafter cited as Burnett]; Cameron, Chase & O'Neal, *Home Birth in Salt Lake County, Utah*, 69 AM. J. PUB. HEALTH 716, 717 (1979) [hereinafter cited as Cameron].

20. See W. ARNEY, POWER AND THE PROFESSION OF OBSTETRICS note 54, at 88-93 (1982); Raymond, *Medicine as Patriarchal Religion*, 7 J. MED. PHIL. 197, 210 (1982) (the World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity); Richards, *The Trouble with "Choice" in Childbirth*, 9 BIRTH 253, 255-56 (1982) ("Obstetrics . . . is characterized by a predominantly physiological or mechanistic approach Most parents do not see birth in such narrow terms. They are much more conscious of its social, emotional and psychological meaning." (footnote omitted)).

21. In his presidential address upon assuming the leadership of the American College of Obstetricians and Gynecologists ("ACOG"), Dr. Brooks Ranney made some subtly revealing remarks:

Medically, we consider a physician to provide quality care if he or she has adequate training and experience to understand the specific problems, to perceive complications in their early phases and correct them, or to treat emergency, debilitating, or life-endangering complications with generally good long-term results. Also, the physician should discern which are the most immediate problems and which are temporarily of lesser importance. Timing of specific treatments should reflect these priorities, although general treatment is of the whole person.

Ranney, *supra* note 15, at 246. Ranney presumably refers to care of the whole *physical* person, as opposed to treatment of the afflicted part requiring immediate attention. Such treatment does not encompass the "whole person" concept that the holistic health movement advocates. Note, for instance, his apparent belief that interpersonal skills are irrelevant to the provision of "quality care":

On the contrary, when women's representatives speak about quality of medical care, they most frequently recommend modifications in the environment surrounding the medical care: more warmth and personal considerateness; less brittle, impersonal officiousness; more empathy; less callous disregard; more willingness of the physician to inform the patient of alternatives, to consult with her, and to allow her to make *some* choices.

....

... We must be willing to adapt to our patients' reasonable requests for modification in the environment surrounding medical care, *providing this can be done without decreasing the true quality of the medical care offered the patient.*

Id. (emphasis added); see also Richards, *supra* note 20, at 256 ("[I]mplicitly or explicitly, the maternity system regards emotional comfort and satisfaction as secondary to the important issue of safety . . .").

22. See, e.g., Gillespie, *Unconventional Health Care: A Positive Alternative?*, FAM. & COMMUNITY HEALTH, Nov. 1979, at 41, 44-45; Mehl & Peterson, *The Berkeley Family Health Center: An Existential Approach to Holistic Health Care*, in 2 COMPULSORY HOSPI-

perceive as an attitude on the part of many doctors that patients are incapable of making intelligent medical choices.²³

Proponents of home birth point both to its social benefits for individuals and families, and to its medical advantages in facilitating labor and reducing complications. While many of these purported advantages are not quantifiable, they are verified individually by those who have experienced home birth.²⁴

From a social perspective, home birth is responsive to each couple's individuality. An intensely personal, family-centered experience, home birth presents an ideal opportunity to experience personal growth and to build relational bonds.²⁵ At home, the specialness and importance of the birth experience in the mother's life can be acknowledged.²⁶ The mother, not the doctor, is primarily responsible for the delivery of the child.²⁷

TALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 541, 541-42 (D. Stewart & L. Stewart eds. 1979) [hereinafter cited as *Health Center*]; Salmon & Berliner, *Health Policy Implications of the Holistic Health Movement*, 5 J. HEALTH POL., POL'Y & L. 535, 536 (1980).

23. Chalmers, *Implications of the Current Debate on Obstetric Practice*, in *THE PLACE OF BIRTH* 44, 45-47 (S. Kitzinger & J. Davis eds. 1978); Krajick, *Home vs. Hospital: Where are Baby, Mother (and Doctor) Safer?*, NEW PHYSICIAN, No. 7, 1982, at 14, 18 (Obstetricians "tend to believe that nonphysicians are incapable of distinguishing among the risks and benefits of the different birth settings.").

24. One mother who has experienced both hospital and home birth states:

I know it's not fashionable to talk about things that can't be measured scientifically, yet many of the advantages of homebirth belong in that category. Unless they've experienced it you can't expect people to understand what it means to give birth to a baby in your own bed, surrounded only by people who love and care about you, and to be in a position to truly celebrate a birth rather than just bravely endure it. The effects of these unmeasurables should not be underestimated.

Tompson, *Custom-Made Delivery*, in *SAFE ALTERNATIVES IN CHILDBIRTH* 141, 143 (D. Stewart & L. Stewart eds. 1976); see also D. STEWART, *THE FIVE STANDARDS FOR SAFE CHILDBEARING* 19 (1981) (The safety of home birth "cannot be completely explained in terms of things we generally regard as medical factors.").

25. See Burt, *Developing Constitutional Rights of, in and for Children*, 39 LAW & CONTEMP. PROBS. 118, 127 (1975) ("[A]n intensely intimate bonding between parent and child lays the best developmental foundation for this society's most prized personality attributes."); Walker, *Improving Maternity Care by Midwifery Research*, NURSING TIMES, Sept. 22, 1977, at 1489 ("The childbearing experience has implications for the future mental, as well as physical, well-being and for the attitudes and relationships of the mother with her husband and children.").

26. See Goldthorp & Richman, *Maternal Attitudes to Unintended Home Confinement: A Case Study of the Effects of the Hospital Strike upon Domiciliary Confinement*, 212 PRACTITIONER 845, 849 (1974); Tompson, *supra* note 24, at 141-42.

27. A birth during which the mother is in control may provide a unique opportunity for resolving inner problems and increasing self-esteem. See, e.g., I. GASKIN, *SPIRITUAL MIDWIFERY* 117 (rev. ed. 1978); Mehl, *Home Delivery Research Today—A Review*, WOMEN & HEALTH, Sept./Oct. 1976, at 3, 8 ("Anesthetized hospital delivery was found to have a humiliating effect with decreases in self-esteem, whereas natural hospital, and more so, home delivery, tended to increase self-worth and self-esteem, and in several cases, result in major

Home birth proponents report that the incidence of postpartum depression is virtually non-existent in home birth mothers.²⁸ Women experiencing such births also tend to bond more intensely with their babies.²⁹

From a medical perspective, it is well established that a relaxed, undisturbed environment and positive emotional support promote the smooth progress of labor.³⁰ Hospital surroundings and attendants, in focusing on the detection of symptoms of abnormality, may produce anxiety-induced complications that would not have occurred in a more favorable environment.³¹ Proponents of home birth argue that "a physical and emotional atmosphere in which sensitivity to needs and intimacy prevail may be more important to the progress of labor and its ultimate outcome than any other single factor."³² In their view, the home setting is ideally suited to such an atmosphere.³³

Home birth also offers potential benefits for improving conventional obstetric practice. First, it serves as a model from which new knowledge and beneficial techniques of non-interventive obstetrics may be acquired.³⁴ Second, by providing competition, it encourages obstetri-

increases in creativity and in breakthroughs in resolving personal problems."); Peterson & Mehl, *Comparative Studies of Psychological Outcomes of Various Childbirth Alternatives*, in 1 21ST CENTURY OBSTETRICS NOW! 209, 234-35 (L. Stewart & D. Stewart eds. 1977).

28. Kelty & Kelty, *Psychological Advantages*, in THE HOME BIRTH BOOK 61, 63 (C. Ward & F. Ward eds. 1976).

29. E.g., Doering & Entwisle, *Preparation During Pregnancy and Ability to Cope with Labor and Delivery*, 45 AM. J. ORTHOPSYCHIATRY 825, 835-36 (1975); Peterson & Mehl, *supra* note 27, at 230-34..

30. See D. HAIRE, THE CULTURAL WARPING OF CHILDBIRTH 6 (1972); Jennings, *Childbirth Choices: Are There Safe Options?*, NURSE PRAC., July-Aug. 1982, at 26, 26; Newton, *The Effects of Fear and Disturbance on Labor*, in 1 21ST CENTURY OBSTETRICS NOW! 61 (L. Stewart & D. Stewart eds. 1977).

31. Bunai, *A Pediatrician's Point of View*, in THE HOME BIRTH BOOK 53, 55 (C. Ward & F. Ward eds. 1976) ("[T]ransportation of the mother to the hospital, labor in an unfamiliar environment, separation from loved ones, unfamiliar personnel and changes in personnel, attempts to accelerate or slow the progress of labor to accommodate personnel without obstetric indication all may have an adverse effect on the outcome of labor."); Laslie, *Ethical Issues in Childbirth*, 7 J. MED. & PHIL. 179, 182 (1982) ("Although many procedures are adopted to safeguard maternal-infant health, there is genuine reason for questioning whether precautions are excessive when we realize that fears of abnormality can give rise to difficulties in labor and delivery and lead to a subsequent need or demand for medical intervention.").

32. Hosford, *Implementing a Medically Sound Childbearing Center: Problems and Solutions*, in 2 21ST CENTURY OBSTETRICS NOW! 311, 317 (L. Stewart & D. Stewart eds. 1977).

33. See Mehl, Peterson, Shaw & Creevy, *Complications of Home Birth*, 2 BIRTH & FAM. J. 123, 129 (1975) [hereinafter cited as Mehl].

34. See Hosford, *supra* note 18, at 29 (home birth movement "may refine our understanding and appreciation of normal labor and birth"); Mehr, *Contemporary Home Childbirth*, NEW PHYSICIAN, Sept. 1980, at 39, 40 ("The obstetrical community has much to learn from the home birth movement, particularly in the area of the impact of emotional state on labor and birth."); Stewart, *Why is There a Need for Alternatives in Childbirth?*, in SAFE ALTERNA-

cians³⁵ and hospitals³⁶ to reevaluate entrenched practices and to respond more effectively to parents' requests.

Home birth, however, is not without its problems. Advocates of home birth readily acknowledge that it is appropriate only for mothers whose pregnancies are normal or "low risk."³⁷ Some obstetricians argue that no screening system is accurate enough to reduce to an acceptable level the possibility of serious complications arising at home.³⁸ Nonetheless, the fact that low risk screening is inexact is not necessarily an insuperable problem. The risk-screening methods some doctors criticize as inadequate for identifying suitable candidates for home birth were not developed to perform that task. Rather, their purpose in the hospital setting is to facilitate the proper allocation of health care personnel, technology, and financial resources.³⁹ Consequently, they are simply rigid checklists of factors based on obstetric history and circumstance-specific physical assessment.⁴⁰ Home birth advocates, however, attribute birth complications to the mother's *total* state—her mind, body, beliefs, emo-

TIVES IN CHILDBIRTH 5, 9 (D. Stewart & L. Stewart eds. 1976) ("While you need good hospitals to back up homebirth programs, hospitals also need good homebirth programs to give them a base of normality by which to measure and stimulate more truly family centered care.")

35. See Rooks, *The Context of Nurse-Midwifery in the 1980s: Our Relationships with Medicine, Nursing, Lay-Midwives, Consumers and Health Care Economist*, J. NURSE-MIDWIFERY, Sept.-Oct. 1983, at 3, 4 ("Obstetrician-gynecologists have had to deal with changes that consumers have demanded, and for which we have provided models. These changes have forced them to alter some of their own ways of giving care."); cf. Adamson & Gare, *Home or Hospital Births?*, 243 J. A.M.A. 1732, 1733 (1980) (Constructive criticism from home birth advocates has motivated changes in hospital procedures.).

36. See *A Public Debate: Resolved: All Mothers Should Give Birth in Hospitals*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 457, 468 (D. Stewart & L. Stewart eds. 1979) (statement of Lewis Mehl, M.D., Director of Center for Research on Birth and Human Development, Berkeley, Cal.) [hereinafter cited as *Debate*].

37. See, e.g., D. STEWART, *supra* note 24, at 201.

38. Some obstetricians suggest that anything less than 100% accuracy could constitute an unacceptable level of risk. See, e.g., New York Academy of Medicine, *Statement and Resolution on the Setting of Obstetrical Delivery*, 59 BULL. N.Y. ACAD. MED. 401, 401 (1983) [hereinafter cited as N.Y. Academy]; cf. Aubry, *Position Paper on Out-of-Hospital Maternity Care*, in 1 21ST CENTURY OBSTETRICS NOW! 33, 35 (L. Stewart & D. Stewart eds. 1977) ("[C]ost savings can never justify even a single maternal death or mentally retarded child, which the in-hospital setting may have prevented.").

39. Mehl & Peterson, *An Existential Approach to Risk Screening and Childbirth Preparation*, in PREGNANCY, CHILDBIRTH, AND PARENTHOOD 225, 225 (P. Ahmed ed. 1981).

40. See Grimes, Mehl, McRae & Peterson, *Phenomenological Risk-Screening for Childbirth: Successful Prospective Differentiation of Risk for Medically Low-Risk Mothers*, J. NURSE-MIDWIFERY, Sept.-Oct. 1983, at 27, 27 [hereinafter cited as Grimes]. See generally Selwyn, *Review of Obstetrical Risk Assessment Methods*, in COMMITTEE REPORT, *supra* note 11, at 149.

tions, and environment.⁴¹ If this perception is accurate, then medical screening methods that ignore such factors are deficient. Indeed, the broader screening approach adopted by home birth practitioners has, in some cases, attained a substantially higher rate of accuracy in identifying high risk populations than would have been achieved by application of medical criteria.⁴²

Nevertheless, a certain number of parents selecting home birth underestimate the potential risk involved.⁴³ There are numerous reported examples of women in the medically high risk category who have opted for home birth.⁴⁴ In addition, even when neither qualified home birth attendants nor personally satisfactory hospital alternatives have been available, many parents still decided to have the birth occur at home.⁴⁵

41. See Grimes, *supra* note 40, at 28.

42. See *id.* at 28-29 (of study group of 315, medical screening was 36.9% accurate and phenomenological screening 95.5% accurate in predicting normalcy); Mehl & Peterson, *supra* note 39, at 245-53.

43. See, e.g., M. CONKLIN & R. SIMMONS, *supra* note 17, at 25 (Twenty-three percent of women sampled said that there were no special risks unique to home deliveries.); Hazell, *supra* note 16, at 14 (Eighteen of twenty women interviewed expressed a low level of concern about hemorrhage and neonatal distress.).

44. See, e.g., Cox, Fox, Zinkin & Matthews, *Critical Appraisal of Domiciliary Obstetric and Neonatal Practice*, 1976 BRIT. MED. J. 84, 84-85 [hereinafter cited as Cox]; Dingley, *Birthplace Alternatives*, OR. HEALTH BULL., Oct. 1977, at 1, 2-3; Gilmore, *Facing the Worst*, MOTHERING, Summer 1980, at 75, 78; Goldthorp & Richman, *supra* note 26, at 852; Hunter, *Mothers & Outlaws*, NEW WEST, Dec. 22, 1980, at 61, 66; *Clinical Curio: Home Birth*, 282 BRIT. MED. J. 1592 (1981).

45. David Stewart has suggested that virtually all parents opting for unattended home births ("UHB") would use qualified attendants if they were available. Stewart, *The Philosophy of Proponents of Home Birth*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 451, 452 (D. Stewart & L. Stewart eds. 1979). Nevertheless, it is clear that at least some couples choose UHB even when qualified attendants are available. Brooks, *Unattended Home Births*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 517, 518 (D. Stewart & L. Stewart eds. 1979).

Stewart has also observed that "[f]or most parents, the choices are between two extremes, both negative: A technological assembly-line hospital delivery of certain risk or a medically unattended birth at home without back-up. In this situation, the safer of these two negatives is often the UHB." D. STEWART, *supra* note 24, at 403. This statement is as extreme as any made by the most narrow-minded obstetrician. In 1981, when it appeared in print, and certainly today, it is fantastic to suggest that *most* parents have no institutional option other than a "technologic assembly-line delivery of certain risk." His bland assurances that, with extra effort to become well-informed and added watchfulness, UHB can be a relatively advantageous alternative, ignore the small amount of statistical evidence and informed commentary in the literature, all of which contradicts this view. See Burnett, *supra* note 19, at 2743-44 (neonatal mortality rate for planned home births in North Carolina, 1974-76, was 4/1000 for births attended by lay midwives, 30/1000 for UHB, despite comparatively favorable low risk characteristics of UHB population); Clarke, *Vital Statistics and Nonhospital Births: A Mortality Study of Infants born Out of Hospital in Oregon*, in COMMITTEE REPORT, *supra* note 11, at 171, 176 (neonatal mortality rate for planned home births in Oregon, 1975-79, was 6.0/1000 for licensed attendants, 3.1/1000 for lay midwives, 13.9/1000 for other and no attendant); cf.

Such decisions are unfortunate. Complications arising during labor and delivery can result in serious injury or even death to the child and can be emotionally devastating for the parents. This is especially troubling in the home birth setting, where parents have assumed the primary responsibility for their child's birth.⁴⁶

Hospital Birth

In addition to seeking the positive advantages of birth in a home setting, many parents who choose home birth are motivated by the desire to avoid what they view as the negative aspects of the hospital birth experience. This section examines problems with present obstetric practices, the hospital setting, and the physician as birth attendant.

Conventional obstetric practices to which critics of hospital birth object include amniotomy, intravenous infusion of labor-stimulating hormones, supine positioning of the mother during labor, episiotomy, forceps delivery and premature cutting of the umbilical cord and delivery of the placenta.⁴⁷ They also criticize the rising incidence of Cesarean section—from 5.5% of hospital births in 1970 to 18.5% in 1982.⁴⁸ Although some doctors have attributed this trend to the increasing inability or unwillingness of women to give birth vaginally,⁴⁹ critics counter that it is the cumulative effects of obstetric interventions that act to “make the woman tense, stymie her physiological processes and prevent her from laboring normally.”⁵⁰

Current obstetric practice relies heavily on technology.⁵¹ Home birth proponents view the dramatic increase in perinatal technology as one of the prime disadvantages of hospital birth. They argue that new

Brooks, *supra*, at 520 (One cannot learn to diagnose from books. “Parents . . . must understand that without the ability to diagnose during labor, they have significantly increased the risk factor for themselves and for their baby.”).

46. See Peterson & Mehl, *supra* note 27, at 209; Ruzek, *Ethical Issues in Childbirth Technology*, in BIRTH CONTROL AND CONTROLLING BIRTH 197, 201 (H. Holmes, B. Hoskins & M. Gross eds. 1980).

47. See generally D. HAIRE, *supra* note 30 and sources cited therein.

48. Otten, *Special Surgery: Controversy Surrounds the Increasing Number of Cesarean Deliveries*, Wall St. J., Jan. 19, 1984, at 1, col. 1; see also *Midwifery Hearings*, *supra* note 17, at 103 (reprinted lecture of C. Arden Miller, M.D.) (c-section rate in some hospitals as high as 23%); Gilstrap, Hauth & Toussaint, *Cesarean Section: Changing Incidence and Indications*, 63 OBSTETRICS & GYNECOLOGY 205, 205 (1984) (20-28% rate).

49. E.g., Stocking, *supra* note 9, at 14 (quoting Dr. Michael Collins, head of obstetrics at Munson Hospital, Traverse City, Mich.).

50. *Id.*

51. Beard, *Childbirth at Home? Mother's Wishes vs Doctor's Duties*, PATIENT CARE, Nov. 15, 1977, at 74.

technology is often rushed into use without rigorous testing⁵² and applied prophylactically to all patients without consideration of individual needs.⁵³

The most prominent example of the increased use of technology in the birth process is the movement toward universal application of electronic fetal monitoring.⁵⁴ Many obstetricians vigorously support this practice,⁵⁵ but proponents of home birth point out that fetal monitoring has been associated with increased rates of cesarean sections with no corresponding improvement in neonatal outcome.⁵⁶

Another obstetric practice to which home birth proponents object is the indiscriminate administration of pain medications during labor and delivery. Medication is used in the vast majority of births in the United States⁵⁷ and most doctors insist that the proper use of pain medication is harmless.⁵⁸ Proponents of home birth, however, argue that credible evidence suggests such medication is not without harmful effects on the

52. See B. ROTHMAN, *IN LABOR: WOMEN AND POWER IN THE BIRTHPLACE* 33 (1982) (electronic fetal monitoring); see also D. HORROBIN, *MEDICAL HUBRIS* 123-24 (1977) ("[E]xpensive and complicated techniques are introduced without any properly controlled trials. Since the desire to have such techniques available . . . seems highly infectious, once one has been acquired they tend to proliferate . . . at enormous cost and with no real benefit . . .").

53. E.g., *Childbirth at Home? U.S. Experts: Safety vs. Sentiment*, *PATIENT CARE*, Nov. 15, 1977, at 118 ("In our present ignorance, [total monitoring] is the goal. We still don't know enough to pick up 100 percent of the babies who are going to develop trouble in labor.") (remark of Edward J. Quilligan, M.D.) [hereinafter cited as *Safety vs. Sentiment*].

54. See generally W. ARNEY, *supra* note 20, at 101-23; Banta, *Benefits and Risks of Electronic Fetal Monitoring*, in *BIRTH CONTROL AND CONTROLLING BIRTH* 183 (H. Holmes, B. Hoskins & M. Gross eds. 1980); Gilfix, *Electronic Fetal Monitoring: Physician Liability and Informed Consent*, 10 *AM. J.L. & MED.* 31 (1984).

55. See, e.g., *Fetal and Neonatal Monitoring: Monitor Every Patient in Labor?*, *PATIENT CARE*, Feb. 28, 1978, at 136.

56. See *Obstetrical Practices in the United States, 1978: Hearings Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources*, 95th Cong., 2d Sess. 50, 52-53 (1978) (testimony of Arnold D. Haverkamp, M.D.) [hereinafter cited as *Obstetrical Practices*]; Gilfix, *supra* note 54, at 39-44; Haverkamp, Thompson, McFee & Cetrulo, *The Evaluation of Continuous Fetal Heart Rate Monitoring in High Risk Pregnancy*, 125 *AM. J. OBSTETRICS & GYNECOLOGY* 310 (1976).

The relationship between monitoring and Cesarean sections is attributable, at least in part, to the defensive reaction of physicians to ambiguous information. See *Obstetrical Practices*, *supra*, at 16 (statement of Arnold D. Haverkamp, M.D.); Gilfix, *supra* note 54, at 78-79.

57. See Stocking, *supra* note 9, at 13 (Ninety-five percent of all hospital births are medicated.); see also Brackbill, McManus, Doering & Robinson, *Exposure to Drugs with Possible Adverse Effects During Pregnancy and Birth*, 9 *BIRTH* 165 (1982) (mothers had little information about potentially teratogenic drugs taken during pregnancy); Doering & Stewart, *The Extent and Character of Drug Consumption During Pregnancy*, 239 *J. A.M.A.* 843 (1978) (all patients in study received at least two drugs during prenatal period; 93.4% received five or more).

58. E.g., R. KRAMER, *GIVING BIRTH* 53-54 (1978); Beard, *supra* note 51, at 92.

baby.⁵⁹ Although doctors often argue against home birth on the ground that the fetus is incapable of giving its consent,⁶⁰ neither is the fetus capable of consenting to conventional obstetric procedures.⁶¹ The same doctors who argue that all "non-medical" desires of the mother should be subordinated to the baby's safe birth, also argue that she has a *right* to pain relief,⁶² thus placing her physical comfort ahead of possibly deleterious health effects for the child.⁶³

Much of the criticism directed at hospital births focuses on the routine obstetric practices mentioned above, but parents also object to features of the hospital setting itself, independent of the specifics of treatment. Such features are identified below as the depersonalization, mechanization, isolation, and routinization that may occur in the hospital experience.

The process of depersonalization begins as soon as the mother arrives at the hospital. She is classified by an identification number and medical status⁶⁴ and may be required to give up her personal belongings.⁶⁵ Numbing or sedating medication typically is administered during labor and delivery. Before entering the delivery room, routine hospital procedures may require the mother's perineal area to be shaved and the administration of an enema.⁶⁶ Taken together, some view these procedures as resulting in the medical alienation of the patient from her body⁶⁷ and total dependence on the medical staff.⁶⁸

59. See *Obstetrical Practices*, *supra* note 56, at 82 (testimony of Doris Haire, President, American Foundation for Maternal and Child Health, New York City); see also S. ARMS, *supra* note 3, at 89; Ettner, *Comparative Study of Obstetrics with Data & Details of a Working Physician's Home OB Service*, in *SAFE ALTERNATIVES IN CHILDBIRTH* 37, 42-43 (D. Stewart & L. Stewart eds. 1976).

60. See Aubry, *supra* note 38, at 183.

61. [T]he fetus cannot give informed consent for delivery in the hospital, . . . for fetal monitoring, cesarean section, or for any other obstetrical procedure. Clearly, it is convenient to require the consent of the fetus for activities which one does not want to occur and to accept the consent of the mother for what one does want to do.

Mehl, *supra* note 27, at 8.

62. *E.g.*, R. KRAMER, *supra* note 58, at 60.

63. See Jennings, *supra* note 30, at 26 ("Concerns with the use of medication in labor and birth include the short-term and long-term effects on the infant . . . Those who continue to champion the use of medication proclaim the advantage of the woman's comfort."); D. HAIRE, *supra* note 30, at 105.

64. S. KITZINGER, *BIRTH AT HOME* 6-7 (1979); N. SHAW, *FORCED LABOR* 66-67 (1974); Stewart & Erickson, *The Sociology of Birth: A Critical Assessment of Theory and Research*, *SOC. SCI. J.*, Apr. 1977, at 33, 43.

65. N. SHAW, *supra* note 64, at 65-66.

66. See *id.* at 67-68; Richards, *supra* note 21, at 256.

67. Gillespie, *supra* note 22, at 46.

68. See N. SHAW, *supra* note 64, at 69.

The mechanization of birth refers to the use of fetal monitoring, IV poles, operating theatre delivery rooms, and numerous other medical apparatus. Proponents of home birth argue that the availability of this technology leads irresistably to its use on both high and low risk patients.⁶⁹ This tendency is particularly strong in teaching hospitals, where trainees naturally seek opportunities to manage "complications."⁷⁰ Moreover, there exists substantial economic incentive to make continuous use of expensive technology.⁷¹ Critics contend that perinatal technology, because it is designed from institutional rather than individual perspectives, tends to consolidate medical control over the birthing process.⁷²

Feelings of isolation in the hospital setting often result from minimal and impersonal contact with hospital staff. This aspect of maternity care has been accentuated by the widespread introduction of electronic fetal monitoring.⁷³

Finally, routinization refers both to arbitrary or restrictive hospital custom and routine and to standardization of treatment. Critics of hospital birth take issue particularly with the latter. They reason that the indiscriminate application of treatment that may be unnecessary or ill-suited for a particular patient undermines the whole notion of safety upon which the superiority of hospital birth is asserted.⁷⁴

Critics of conventional birth observe that medical training itself may

69. See Adams, *The Use of Obstetrical Procedures in the Care of Low-Risk Women*, 8 WOMEN & HEALTH 25, 31 (1983).

70. See R. KRAMER, *supra* note 58, at 134; N. SHAW, *supra* note 64, at 27.

71. *Infant Mortality Oversight Hearings Before the Subcomm. on Fiscal Affairs and Health of the House Comm. on the District of Columbia*, 97th Cong., 2d Sess. 28 (1982) (report of the Women's Health Project) ("Without enough high-risk patients to serve . . . hospitals have an added incentive to use specialized services in low-risk cases.") [hereinafter cited as *Infant Mortality*].

72. See Mulligan, *Professional Transition: Nurse to Nurse-Midwife*, 24 NURSING OUTLOOK 228, 232 (1976); Ruzek, *supra* note 46, at 198 ("Insofar as childbirth is defined by the 'experts' as a high risk, high technology medical event, the relative power of the patient or the birthing family is predictably low").

73. *Midwifery Hearings*, *supra* note 17, at 111 (reprinted address of C. Arden Miller, M.D.) ("Technology can . . . breed benign neglect and false security. Women in labor report that the fetal monitoring wires issuing from the vagina provide a cold comfort as compared with the physical presence of a reassuring and caring person."); Jarzembksi, *Benefits, Limitations, Fallacies and Hazards of Electronic Monitoring of the Human Body*, in 1 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 143, 158 (D. Stewart & L. Stewart eds. 1979) ("[M]edical support personnel may develop an over reliance on the monitoring devices with an attendant lack of personal attention to the patient. Personal attention may have more therapeutic value than the gathering of information by the monitor."); see *supra* notes 54-56 & accompanying text.

74. S. KITZINGER, *supra* note 64, at 6; Richards, *supra* note 20, at 256.

lie at the heart of the problem. Virtually the entire focus of medical training is on the detection and treatment of complications of pregnancy and labor and related interventions.⁷⁵ The result of this preoccupation is a continual narrowing of the concept of "normality" as obstetricians seek ways to employ their skill at treating and correcting the abnormal.⁷⁶ Technology is heavily emphasized;⁷⁷ thus, routine use of technology increases, and manual skills are lost through disuse.⁷⁸

The increasing criticism leveled at hospital obstetrics during the 1970s has had an impact on hospital procedures.⁷⁹ Many hospitals have officially adopted the concept of "family-centered care,"⁸⁰ although clearly it has not been universally embraced.⁸¹ Changing hospitals to be more responsive to parents' concerns potentially could recapture many of those who have turned to alternative birth settings. Although the hospital will never duplicate the home, advocates propose home-like hospital deliveries as the best of both worlds.⁸² Unfortunately, changes in hospital practices are not always responsive to parents' needs and concerns.

75. See N. SHAW, *supra* note 64, at 28; D. STEWART, *supra* note 24, at 90-95 (evaluation of the standard obstetrical textbook, J. PRITCHARD & P. MACDONALD, *WILLIAMS OBSTETRICS* (15th ed. 1976)); Carver, *The Deliverer: A Woman Doctor's Reflections on Medical Socialization*, in *CHILDBIRTH: ALTERNATIVES TO MEDICAL CONTROL* 122, 132-33 (S. Romalis ed. 1981); Ranney, *supra* note 15, at 246 (purpose of regular prenatal examinations by obstetricians and of experienced obstetric care during labor, delivery, and the postpartum period is to recognize and treat early signs of complications).

76. See Chalmers, *supra* note 23, at 48 ("[I]t appears that an increasing proportion of pregnant women are seen as 'abnormal' or at 'increased risk.'").

77. See Montagu, *Social Impacts of Unnecessary Intervention and Unnatural Surroundings in Childbirth*, in *2 21ST CENTURY OBSTETRICS NOW!* 589, 590-91 (L. Stewart & D. Stewart eds. 1977).

78. See, e.g., R. KRAMER, *supra* note 58, at 158; B. ROTHMAN, *supra* note 52, at 288; Corea, *The Caesarian Epidemic: Who's Having this Baby Anyway—You or the Doctor?*, *MOTHER JONES*, July 1980; see also D. STEWART, *supra* note 24, at 52 (vaginal feet-first delivery or "breech birth" no longer taught in medical schools). Critics also note that obstetricians may never witness a truly relaxed and natural birth or attend a woman continually throughout an entire labor, see Carver, *supra* note 75, at 147-48, and therefore, that it is little wonder that most obstetricians feel safer in the hospital, where the technology and procedures on which they have come to rely are available. Davis, *The Place of Birth*, 57 *ARCHIVES DISEASE CHILDHOOD* 406, 406-07 (1982); see Huntingford, *Obstetric practice: Past, Present and Future*, in *THE PLACE OF BIRTH* 229, 248 (S. Kitzinger & J. Davis eds. 1978).

79. See, e.g., Aubry, *supra* note 4, at 22-23.

80. See N.Y. Academy, *supra* note 38, at 402.

81. See, e.g., *Midwifery Hearings*, *supra* note 17, at 31 (testimony of William Darrell Martin, M.D.); R. KRAMER, *supra* note 58, at 116-17 (Suburban and community hospitals lag behind urban medical centers in liberalizing birthing practices.).

82. See, e.g., R. KRAMER, *supra* note 58, at 207-08; Newton, *Woman, Wife, Mother: What's Best for Newborns and Parents—Giving Birth in the Hospital or at Home?*, *FAM. HEALTH*, Jan. 1977, at 19, 20; *Safety vs. Sentiment*, *supra* note 53, at 112 (remark of Marshall H. Klaus, M.D.).

Critics complain that too often when hospitals have installed birthing suites, "the special rooms appear to be concessions without conviction, a parody of what many women are really seeking."⁸³

The real demand, of course, is for a change in attitudes rather than surroundings. Many hospitals, however, have established birthing rooms solely for economic purposes, not because their thinking has changed.⁸⁴ Organizational and professional inertia often tend to conform "natural childbirth" in the hospital setting to the medical model.⁸⁵ The emphasis is on coaxing parents back into the system rather than on accommodating their preferences in the birthing process. Hospitals, for example, may establish alternative settings for normal births, but apply extremely narrow criteria of normality.⁸⁶ Once mothers are classified as high risk and are transferred to the regular labor and delivery suite, seeking other options may no longer be practical.

Assessing Risk

For all the purported advantages of various childbirth alternatives and criticisms of conventional obstetrics, perinatal and maternal mortality figures have progressively improved, a fact for which the advocates of hospital birth readily take credit.⁸⁷ While conceding that patients' personal needs could be better served, they question whether birth is the appropriate context in which to make a stand for individual rights and

83. *Midwifery Hearings*, *supra* note 17, at 117 (reprinted address of C. Arden Miller, M.D.); see also B. ROTHMAN, *supra* note 52, at 48; Klein & Westreich, *Birth Room Transfer and Procedure Rates—What Do They Tell About the Setting?*, 10 BIRTH 93, 96 (1983) (staff's attitude, rather than appearance of birth room, is critical).

84. See Klein & Westreich, *supra* note 83, at 96-97 ("[T]he birth room may be recognized as primarily a hospital marketing device for either filling empty obstetrical beds or attracting a few women who might otherwise have delivered at home."); *Debate*, *supra* note 36, at 470 (statement of Gary Richwald, M.D.).

85. See Rothman, *Awake and Aware, or False Consciousness: The Cooption of Childbirth Reform in America*, in *CHILDBIRTH: ALTERNATIVES TO MEDICAL CONTROL* 150, 150-52 (S. Romalis ed. 1981); Swallow, *Midwives in Many Settings*, in *BIRTH CONTROL AND CONTROLLING BIRTH* 245, 249 (H. Holmes, B. Hoskins & M. Gross eds. 1980).

86. See B. ROTHMAN, *supra* note 52, at 47-48. Compare Lubic, *Alternative Childbirth Experiences*, in *PREGNANCY, CHILDBIRTH, AND PARENTHOOD* 273, 283 (P. Ahmed ed. 1981) (Twenty percent of families initially seeking care at MCA Childbearing Center in New York City withdrew from or "risked out" of the program before labor; ninety percent of those presenting themselves for intrapartum care gave birth there.) with Saldana, Rivera-Alsina, Arias, Ross & Pokorny, *Home Birth: Negative Implications Derived from a Hospital-Based Birthing Suite*, 76 S. MED. J. 170, 171 ("Only 160 (41%) of 390 patients who entered the third trimester while registered in the program actually gave birth in the birthing suite.") [hereinafter cited as Saldana].

87. E.g., *Obstetrical Practices*, *supra* note 56, at 192-95 (testimony of George Ryan, M.D.); Aubry, *supra* note 4, at 16-17; *Debate*, *supra* note 36, at 461 (statement of Richard Aubry, M.D.).

against experts and institutions, or to seek a cathartic experience.⁸⁸

Risk has two components—probability and severity. A particular occurrence might produce harmful results, but if its incidence is rare the “risk factor” may be regarded as low. At some point, however, the “worst case” is so cataclysmic that any avoidable increase in probability, however low the “risk factor” remains, may be unacceptable. This section considers the notion of risk in childbirth in terms of physical outcome. First, it examines empirical data on birth settings, analyzing in effect the “probability” element of the risk equation. It then balances alternatives in specific contexts, thus focusing on the “severity” factor.

Statistical evidence proffered on the relative safety of home and hospital birth may be deceptive. For example, public health statistics cited by the American College of Obstetricians and Gynecologists to show that home birth is two to five times more likely to result in an infant's death have been heavily criticized for including unplanned out-of-hospital births, which often occur en route to the hospital or involve premature infants.⁸⁹ Similarly, two forms of statistical evidence of limited usefulness offered in support of home birth are historical⁹⁰ and foreign⁹¹ data. The obvious shortcoming of historical data is that the data cannot take into account medical advances that may have allowed the hospital to surpass the home in safety. As to foreign data, there are too many uncontrolled variables to draw meaningful comparisons.⁹²

88. Many of us want our lives to be richer, more fully experienced, to feel more in control of our fate and less dependent on institutions and instruments that make us passive and dependent. But perhaps the hour of childbirth is not always the best one in which to seek this kind of experience. Not, at any rate, by turning our backs on what medical knowledge and experience can offer to ensure a degree of safety that nature alone does not always provide—not, that is, by rejecting the hospital and staying at home to labor and deliver.

R. KRAMER, *supra* note 58, at 210.

89. See, e.g., M. CONKLIN & R. SIMMONS, *supra* note 17, at 5; DEPARTMENT OF HUMAN RESOURCES, REPORT ON MIDWIFERY TO THE NORTH CAROLINA GENERAL ASSEMBLY 7 (1983) [hereinafter cited as N.C. REPORT]; Estes, *A Home Obstetric Service with Expert Consultation and Back-Up*, 5 BIRTH & FAM. J. 151, 156 (1978); Hinds, Bergeisen & Allen, *Neonatal Outcome in Planned vs. Unplanned Out-of-Hospital Births in Kentucky*, 253 J. A.M.A. 1528, 1578 (1985) [hereinafter cited as Hinds]; Shy, Frost & Ullom, *Out-of-Hospital Delivery in Washington State, 1975 to 1977*, 137 AM. J. OBSTETRICS & GYNECOLOGY 547, 551-52 (1980) [hereinafter cited as Shy].

90. See, e.g., D. STEWART, *supra* note 24, at 116-43.

91. Most commonly cited is the example of The Netherlands. See, e.g., S. ARMS, *supra* note 3, at 346-72; D. STEWART, *supra* note 24, at 223-33; Kloosterman, *The Dutch System of Home Births*, in THE PLACE OF BIRTH 85 (S. Kitzinger & J. Davis eds. 1978).

92. See HEALTH POLICY ANALYSIS PROGRAM, MIDWIFERY OUTSIDE THE NURSING PROFESSION: THE CURRENT DEBATE IN WASHINGTON 25 (School of Public Health and Community Medicine, University of Washington, Oct. 1980) [hereinafter cited as WASHINGTON DEBATE]; R. KRAMER, *supra* note 58, at 219; B. ROTHMAN, *supra* note 52, at 42.

More meaningful figures are provided by public health statistics for home births broken down by whether the birth was planned or unplanned and factors such as race and the presence of attendants.⁹³ This data shows that home birth outcomes appear to be reasonably comparable to those achieved by hospitals.⁹⁴ The suspicion, however, that large numbers of home births and home birth fatalities are not registered and hence not included in the figures⁹⁵ undermines their reliability. Home birth advocates, on the other hand, argue that the figures appear worse than they actually are, since home births are more likely to be reported when complications arise.⁹⁶ Even so, deaths occur so infrequently that it is likely that a few unreported fatalities would have a greater relative effect on home birth outcome figures than would a large number of unreported births.

Another category of statistics, those from detailed studies of particular populations,⁹⁷ avoids the reliability problems of the data discussed above, but many argue that figures derived from such self-selected groups

93. See generally Burnett, *supra* note 19; Clarke, *supra* note 45; Dingley, *supra* note 11; Hinds, *supra* note 89.

94. Simmons & Bernstein analyzed disaggregated data for Michigan from 1972-1979. They hypothesized that the precipitous drop in neonatal mortality for out-of-hospital births during that period was a feature of the increasing number of planned home births, while unplanned home births remained constant. Simmons & Bernstein, *supra* note 13, at 169. Another guide used in discerning planning status and outcome was birthweight. For the period 1975-1979, the hospital neonatal mortality rate for births over 2500 g. was 2.41/1000; for home births it was 3.94/1000. *Id.* at 167.

95. See L. BARTON, *supra* note 13, at 7; Adamson & Gare, *supra* note 35, at 1734; Burnett, *supra* note 19, at 1734; Shy, *supra* note 89, at 552; *supra* note 9 & accompanying text.

96. See Mehr, *supra* note 34, at 39; Stewart & Mehl, *A Rebuttal to Negative Home Birth Statistics Cited by ACOG*, in 1 21ST CENTURY OBSTETRICS NOW! 27, 28 (L. Stewart & D. Stewart eds. 1977).

Unreported neonatal hospital deaths also are not uncommon (and these *certainly* are not offset by large numbers of unreported births). See McCarthy, Terry, Rochat, Quave & Tyler, *The Underregistration of Neonatal Deaths: Georgia 1974-77*, 70 AM. J. PUB. HEALTH 977, 979 (1980).

97. See, e.g., Estes, *supra* note 89, at 154-56; Fremont Birth Collective, *Lay Midwifery—Still an Illegal Profession*, WOMEN & HEALTH, Nov./Dec. 1977, at 19, 24; Gaskin, *Community Alternatives to High Technology Birth*, in BIRTH CONTROL AND CONTROLLING BIRTH 223 (H. Holmes, B. Hoskins & M. Gross eds. 1980) (The Farm Community in Tennessee); Koehler, Solomon & Murphy, *Outcomes of a Rural Sonoma County Home Birth Practice: 1976-82*, 11 BIRTH 165 (1984); Mehl, *Research on Alternatives in Childbirth: What Can It Tell Us About Hospital Practice?*, in 21ST CENTURY OBSTETRICS NOW! 171 (L. Stewart & D. Stewart ed. 1977) (retrospective matching and analysis of 1046 physician and midwife-attended home births to 1046 hospital births); Mehl, *Comparisons*, *supra* note 9 (retrospective matching and analysis of 502 home births attended by lay midwives screened for competence with 502 physician-attended births); Mehl, *supra* note 33 (series of 287 home births attended by lay midwives of Santa Cruz Birth Center from 1971-73); Sullivan & Beeman, *Four Years' Experience with Home Birth by Licensed Midwives in Arizona*, 73 AM. J. PUB. HEALTH 641 (1983).

do not reflect the general situation. Moreover, opponents of home birth argue that these studies are misleading because they compare figures from home births occurring under optimal circumstances with average figures for hospital births.⁹⁸

Most likely, a comprehensive home-hospital study that precisely categorizes and quantifies risks will never be done, and may be functionally and ethically impossible to design.⁹⁹ Nevertheless, the medical profession may all too easily dismiss evidence that contradicts doctors' inherent belief in the superiority of hospital births,¹⁰⁰ and may give too little weight to doctor-caused or treatment-related illness or injury.¹⁰¹

Opponents of home birth make their strongest arguments when they point to the "worst case" scenario, the emergency in which even a few minutes' delay can result in death or injury to the mother or infant. Certain life-threatening conditions will occur unpredictably in a small but irreducible number of cases.¹⁰² Proponents of hospital birth argue that these and other emergencies occur suddenly,¹⁰³ that physician back-up and medical facilities are too remote to be of assistance in such cases,¹⁰⁴ and, consequently, that the home simply cannot match the hospital for

98. See, e.g., Shy, *supra* note 89, at 552.

99. See COMMITTEE REPORT, *supra* note 11, at 25-28; Chalmers, *supra* note 23, at 51; Krajick, *supra* note 23, at 16; Simmons & Bernstein, *supra* note 13, at 168-69. Such a study is unlikely because it would be impossible to assign subjects randomly to home or hospital delivery.

100. See Foster, *supra* note 12, at 32. A past president of the American College of Obstetricians and Gynecologists has stated:

"We're never going to have a completely controlled and reliable study. It can't be done, and it won't be done . . . We have to base our opinions on the best available evidence and on common sense, and they indicate that the safety of the home is far less than in the hospital."

Krajick, *supra* note 23, at 16 (quoting Dr. Harold Kaminetzky).

101. Chalmers, *supra* note 23, at 50. One interesting example is Saldana's review of outcomes from a hospital alternative birthing room ("ABC"). He concludes that the incidence of complications and cases of maternal and neonatal morbidity occurring in the ABC population suggests that home birth is unsafe even for such a low risk group. Saldana, *supra* note 86, at 172. That conclusion rests on the assumption that the same complications would have arisen at home, i.e., that they were not attributable to the hospital or doctors themselves. In fact, Klein's study of ABC's found that variations between hospitals' inpatient transfer rates from ABC's to regular labor wards were directly related to whether or not attitudes of the staff, rather than simply decor, had changed. Klein & Westreich, *supra* note 83, at 96.

102. Such life-threatening conditions include prolapse of the umbilical cord, placental abruption, and respiratory distress for the infant, and postpartum hemorrhage for the mother. See Adamson & Gare, *supra* note 35, at 1733; Starr, *Home Delivery of Babies: Rewards vs. Risks*, MOTHER EARTH NEWS, May 1971, at 50, 52.

103. See, e.g., Maxwell, *The Obstructed Labor-Medical Syndrome*, TRIAL, May 1983, at 57, 61.

104. See, e.g., Saldana, *supra* note 86, at 172 ("The concept of physician back-up' is a fallacy, since it only creates a false sense of security for the couple and their home birth attend-

safety.¹⁰⁵ Advocates of home birth respond that the risk of such catastrophic emergencies, while real, is overstated.¹⁰⁶ They contend that serious complications rarely develop suddenly, and suggest that complications only *appear* to doctors to occur suddenly because, unlike midwives, doctors see women in labor only intermittently.¹⁰⁷

Against the risks of nonhospital births, home birth advocates balance the effects of iatrogenic injury. The potential for such injury certainly exists.¹⁰⁸ Moreover, the more medically sophisticated the facility, the more likely will be the use of intervention and the potential for consequent injury.¹⁰⁹ Even advocates of hospital delivery caution that its advantage in safety is realizable only if the highest standards of care are followed.¹¹⁰ Clearly, not all hospitals meet such standards.¹¹¹

The focal point of the debate seems to be the very small number of deaths that will occur specifically because a birth occurs at home but that could have been prevented in the hospital. Even accepting that outcomes of home and hospital births are comparable statistically, the underlying inference of hospital birth advocates is that these "worst case" avoidable

ant. It is obvious that little could be accomplished by a physician who is away from the scene.").

105. See, e.g., Aubry, *supra* note 4, at 20.

106. See, e.g., D. HAIRE, *supra* note 30, at 15; Raisler, *Interview with a Rural Midwife*, J. NURSE-MIDWIFERY, Winter 1978, at 36, 38. Examples of the incidence of such complications in out-of-hospital deliveries are provided by the Childbearing Center in New York City and by The Farm Community in Tennessee. See Gaskin, *supra* note 97, at 224-26 (statistics for 1000 births, 1970-1979: two abruptions, one prolapse, six cases of maternal hemorrhage necessitating transfusion; although the statistics are somewhat unclear, two of these were anticipated before the onset of labor and occurred during births planned for and taking place at the hospital).

107. See *Midwifery Hearings*, *supra* note 17, at 13 (prepared statement of Sally Tom, American College of Nurse-Midwives); *id.* at 148 (testimony of Judith Rooks, C.N.M.).

108. See *id.* at 147 (testimony of Judith Rooks, C.N.M.) ("[S]ome women who would otherwise have had a normal labor and delivery and a healthy baby, develop serious complications . . . as a result of these medical procedures."); Beard, *supra* note 51, at 93 ("Intervention is resulting in iatrogenic pathology in women and their babies who might well have had spontaneous vaginal deliveries if they had been left alone."); Birnbaum, *The Iatrogenesis of Damaged Mothers and Newborns*, in 1 21ST CENTURY OBSTETRICS NOW! 105 (L. Stewart & D. Stewart eds. 1977); cf. Steel, Gertman, Crescenzi & Anderson, *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 NEW ENG. J. MED. 638 (1981) (36% of 815 consecutive patients diagnosed as having iatrogenic illness).

109. See, e.g., Baruffi, Strobino & Dellinger, *Definitions of High Risk in Pregnancy and Evaluation of their Predictive Validity*, 148 AM. J. OBSTETRICS & GYNECOLOGY 781, 786 (1984) [hereinafter cited as Baruffi]; *supra* notes 69-70 & accompanying text.

110. See Beard, *supra* note 51, at 84 ("I am convinced that hospital delivery is safest. In the same breath, I also have to say that hospital delivery is only best if standards of practice are of the highest order.").

111. See S. KITZINGER, *supra* note 64, at 6; R. KRAMER, *supra* note 58, at 134; Ruzek, *supra* note 46, at 199.

home birth fatalities are attributable to a deliberate act and hence are in a class distinct from the consequences of human error and accident.

Despite the risks inherent in home birth, those who choose this option often feel that safety and physical comfort are not absolutes. Other nonmedical values weigh heavily in their decision.¹¹² At some point, the *right* to choose, rather than the medical validity of the choice, becomes the ascendant issue. As one commentator pointed out, "The crucial question, then, is who in society is allowed to define what constitutes an acceptable risk, including possible death?"¹¹³ The next section of this Article addresses that problem.

Legal Perspectives—Prioritizing Rights and Duties

Although they support their arguments with evidence of safety and relative risk, advocates of alternatives in childbirth assert fundamentally that parents have the *right* to choose where, how, and with whom their children are born.¹¹⁴ Critics of such unfettered choice argue that society has a duty to protect the vulnerable child.¹¹⁵ This section evaluates the legal bases of the various rights and duties advanced in connection with childbirth. First, it examines the present state of the law concerning midwifery and home birth. Then, recognizing the indeterminate character of the law in this area, it analyzes the sources and scope of rights and duties conceptually relevant to decisions concerning childbirth. Finally, it examines the constitutional question of whether there exists a fundamental right of parental choice in childbirth.

112. See Luce, *Ethical Issues Relating to Childbirth as Experienced by the Birthing Woman and Midwife*, in *BIRTH CONTROL AND CONTROLLING BIRTH* 239, 242 (H. Holmes, B. Hoskins & M. Gross eds. 1980) ("For the woman giving birth, the medical dimension of what is happening is not the most important one any more than it is for the dying person. Life-supporting procedures cannot be allowed to impinge upon or replace values and experiences that are equally life-sustaining.").

113. Ruzek, *supra* note 46, at 200. See generally Note, *The Limits of State Intervention: Personal Identity and Ultra-Risky Actions*, 85 *YALE L.J.* 826 (1976) (discussion of political and philosophical justification for state regulation of activity dangerous only to those regulated).

114. See, e.g., I. GASKIN, *supra* note 27, at 11 ("The midwives represented in this book feel that the rights of women, the newborn, and the family during the passage of childbirth are among those unenumerated rights which are to be retained by the people."); Hosford, *supra* note 18, at 29 ("[T]his being able to choose—according to one's own feelings, needs, idiosyncracies, ideals and hangups—is in essence the greatest single blessing of the home birth movement and the development of alternatives in childbirth.").

115. See, e.g., Finch, *Paternalism and Professionalism in Childbirth—I*, 132 *NEW L.J.* 995, 995-96 ("There is a lot of talk in some quarters these days about 'rights' to choose in relation to matters of childbirth and pregnancy which conveniently omit consideration of the choice which responsible society should make available to its members who are so vulnerable or immature that they are not in a position to make a real choice on their own accord.").

Present State of the Law

Midwifery is regulated, directly or indirectly, under a widely divergent set of statutory formulae. Often, the statutory law is so indefinite that public sentiment becomes the crucial determinant of legal status.¹¹⁶ The law directly applicable to home birth is even more uncertain, based on a few outdated court decisions and vague statutory pronouncements. More importantly, the constitutional dimensions of the controversy have yet to be faced squarely.¹¹⁷ As such, the law described below concerning midwifery and home birth cannot be considered determinative.

Eighteen states¹¹⁸ have no explicit statutory treatment of lay midwifery. In those states in which courts have ruled on the legal status of lay midwifery, the crucial issue has been whether midwifery constitutes the practice of medicine.¹¹⁹ Specific references in vital statistics¹²⁰ and eye prophylaxis¹²¹ statutes to both doctors and midwives have been taken as indications that legislatures considered midwifery to be a profession distinct from the practice of medicine.¹²² This reasoning could prove ap-

116. See *infra* Appendix note 31; P. SALLOMI, *supra* note 5, at 3; Cumings, *The Paradox of Restrictive Midwifery Law: How Can Safe Home Birth with a Skilled Midwife be Illegal when Birth Alone or with an Incompetent Doctor is Legal?*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 591, 591-93 (D. Stewart & L. Stewart eds. 1979).

117. There are two basic constitutional claims—that home birth is encompassed within the marital right of privacy, and that the right of privacy includes one's choice of an unlicensed birth attendant. An additional consideration is whether, if the former claim is legitimate, the latter necessarily must follow.

118. The term "states" as used in this discussion includes the District of Columbia. The 18 states are California, Idaho, Indiana, Iowa, Kansas, Maine, Massachusetts, Michigan, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, Wisconsin, and Wyoming. See *infra* Appendix notes 7, 15, 18-20, 23, 25-26, 32-33, 40, 42-43, 47, 50-51, 55 & 56.

119. For cases indicating that midwifery may fall within the coverage of state medical practice acts, see *Bowland v. Municipal Court*, 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976); *Smith v. State ex rel. Medical Licensing Bd.*, 459 N.E.2d 401 (1984); *Commonwealth v. Porn*, 196 Mass. 326, 82 N.E. 305 (1907). But see *Leigh v. Board of Registration in Nursing*, 395 Mass. 670, 481 N.E.2d 1347 (1985) (distinguishing *Porn*). Absent other factors, the breadth of the wording of the particular statute's definition of the practice of medicine may be determinative. In *Bowland*, the court examined the wording of a statute that listed certain activities that could be conducted only with a license. The court found that language referring to treatment of "any mental or physical condition" was broad enough to encompass midwifery. *Bowland*, 18 Cal. 3d at 491, 556 P.2d at 1086-87, 134 Cal. Rptr. at 635; see *Caldwell*, *Bowland v. Municipal Court Revisited: A Defense Perspective on Unlicensed Midwife Practice in California*, 15 PAC. L.J. 19, 29-30 (1983); Comment, *Restrictions on Unorthodox Health Treatment in California: A Legal and Economic Analysis*, 24 UCLA L. REV. 647 (1977).

120. The most common of these provisions requires that the person in attendance at a birth file a birth or death certificate. See, e.g., VT. STAT. ANN. tit. 18, § 5071(a) (Supp. 1985).

121. Such statutes require treatment of the newborn's eyes with silver nitrate to prevent gonorrheal infection. See, e.g., N.D. CENT. CODE § 23-07-10 (1978).

122. See *People v. Hildy*, 289 Mich. 536, 286 N.W. 819 (1939); *Pierce v. Douglas County*

plicable in a number of states in which the courts have not yet addressed the question.¹²³

The remaining states in some way explicitly permit or prohibit the practice of lay midwifery. Nine states issue licenses to lay midwives,¹²⁴ and two permit them to practice without regulation.¹²⁵ Nine explicitly prohibit lay midwifery,¹²⁶ while nine states limit its practice to holders of licenses on or before a certain date.¹²⁷ In four states, statutes authorize the licensing of lay midwives, but the licenses are unavailable from the designated regulatory authorities.¹²⁸ It is likely that in these states, as in states in which lay midwifery is clearly prohibited, midwives simply practice without legal sanction.

Several states provide noteworthy statutory exemptions from their licensing provisions. Oklahoma exempts from its nurse-midwifery statute the practice of lay midwifery "in connection with spiritual convictions and practices of any established church or religious denomination."¹²⁹ Similarly, Utah's nurse-midwifery act states that it "shall in no way or at any time abridge, limit or change in any way the right of a mother and/or father to deliver their own baby where, when, how and with whom they choose regardless of certification."¹³⁰ The Arizona lay midwifery statute, while clearly prohibiting the practice of unlicensed individuals,¹³¹ states that it "shall not abridge, limit or change the right of a mother or father to deliver their own baby."¹³²

The constitutional status of lay midwifery has yet to be addressed definitively. Some claim that the parents' right of marital privacy encompasses childbirth and, consequently, their choice of attendant. In

Dist. Attorney, No. 12273 (9th Dist. Ct. Nev. Feb. 19, 1982); *Banti v. State*, 163 Tex. Crim. 89, 289 S.W.2d 244 (1956).

123. States in this category with such provisions are Maine, Nebraska, North Dakota, Oregon, South Dakota, and Vermont. See *infra* Appendix notes 23, 32, 40, 43, 47 & 51.

124. Alaska, Arizona, Arkansas, New Hampshire, New Jersey, New Mexico, South Carolina, Texas, and Washington; see *infra* Appendix notes 3, 5-6, 34-36, 46, 49 & 53.

125. Mississippi and Tennessee; see *infra* Appendix notes 29 & 48.

126. Colorado, Connecticut, Delaware, Hawaii, Maryland, Montana, New York, Pennsylvania, and West Virginia; see *infra* Appendix notes 8-10, 14, 24, 31, 37, 44 & 54.

127. Alabama, Florida, Illinois, Kentucky, Louisiana, Missouri, North Carolina, Ohio, and Virginia; see *infra* Appendix notes 2, 12, 16, 21-22, 30, 39, 41 & 52. States with such provisions in which it is clear that there are no longer any licensees active are placed in the "prohibited" category. E.g., Hawaii; see *infra* Appendix note 14.

128. District of Columbia, Georgia, Minnesota, and Rhode Island; see *infra* Appendix notes 11, 13, 28 & 45.

129. OKLA. STAT. tit. 59, § 577.6 (1981).

130. UTAH CODE ANN. § 58-44-11 (Supp. 1983).

131. ARIZ. REV. STAT. ANN. § 36-757(2) (Supp. 1983).

132. *Id.* § 37-752(B).

Barasa v. Anderson,¹³³ a case challenging an Illinois statute terminating licensing of lay midwives, the plaintiff parents' claim was dismissed on the ground that they failed to assert a fundamental right. The California Supreme Court in *Bowland v. Municipal Court*¹³⁴ provided a more thorough consideration of the constitutionality of restrictions on the practice of lay midwifery. The court rejected the claim that the right of privacy encompassed choice of an unlicensed birth attendant.¹³⁵ Interim developments, however, in both state and federal constitutional law, have rendered the *Bowland* decision suspect.¹³⁶

No laws require women to give birth in a hospital or with a physician in attendance.¹³⁷ However, a number of outcome-oriented rationales¹³⁸ have been suggested under which a duty to seek medical aid is posited and criminal or civil liability potentially incurred for breach of that duty. The scant case law on incidents involving home birth sheds meager light on such theories. In a few older cases in which infants died during home births, mothers or husbands were charged with manslaughter for failing to arrange for aid during labor.¹³⁹ The generally accepted rule, adopted on the basis of English precedent by the Wyoming Supreme Court in *State v. Osmus*,¹⁴⁰ is that there is no prebirth duty to seek assistance. Although one commentator suggests that these cases rely on a false distinction between omissions occurring before and after the moment of birth,¹⁴¹ a more accurate reading seems to be that, absent willfulness or at least gross negligence on the part of the person charged,¹⁴² no criminal

133. No. 77 C 3383 (N.D. Ill. Mar. 19, 1981). See *infra* Appendix note 16.

134. 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976).

135. *Id.* at 495, 556 P.2d at 1089, 134 Cal. Rptr. at 638.

136. For subsequent California decisions, see Caldwell, *supra* note 119, at 19-21, 27-28. Elements of the opinion of the United States Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973), on which the *Bowland* court relied, have since been elaborated in numerous decisions, the most recent being *Thornburgh v. American College of Obstetricians & Gynecologists*, 106 S. Ct. 2169 (1986).

137. See Annas, *supra* note 15, at 19; Cumings, *supra* note 116, at 593.

138. See Annas, *Legal Aspects of Homebirths and Other Childbirth Alternatives*, in SAFE ALTERNATIVES IN CHILDBIRTH 161, 169 (D. Stewart & L. Stewart eds. 1976) ("The law is generally concerned with outcomes. Therefore, . . . unless the mother or child dies or is permanently disabled . . . , it is unlikely that there would be any legal action taken against the parents, a friend of the family, a midwife, or a physician for participating in a homebirth.").

139. See, e.g., *People v. Chavez*, 77 Cal. App. 2d 621, 176 P.2d 92 (1947); *State v. Shephard*, 255 Iowa 1218, 124 N.W.2d 712 (1963); *Commonwealth v. Signerski*, 14 Pa. D. 1361 (1905); *State v. Osmus*, 73 Wyo. 183, 276 P.2d 469 (1954).

140. 73 Wyo. 183, 200-01, 276 P.2d 469, 475-76 (1954).

141. See Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 218 n.34 (1975).

142. Professor Robertson cites *State v. Shephard*, 255 Iowa 1218, 124 N.W.2d 712 (1963), as taking a better approach. Robertson, *supra* note 141, at 218 n.34 ("whether, with birth

liability should result from the child dying during, or immediately after, birth.¹⁴³

Some argue that medical skills have advanced and community attitudes shifted to the point where home birth per se might be regarded as recklessness.¹⁴⁴ Nevertheless, recent criminal prosecutions have been directed against the lay midwife or physician rather than the parents involved in home births.¹⁴⁵ In the event of a civil suit filed against the midwife or physician in attendance at a home birth, if in-hospital birth were deemed to be the accepted standard of care, failure to hospitalize could be regarded as de facto negligence. One commentator has argued that absent *actual* negligence, such a presumption would not be available to knowledgeable parents seeking an attendant for a home birth and fully informed of its risks.¹⁴⁶ It is not clear, however, that this "assumption of

imminent, a reasonable person would have obtained medical care"). The *Shephard* court, however, places primary emphasis on the fact that the circumstances of the birth were "sufficient to justify an inference of malice." *Shephard*, 255 Iowa at 1235, 124 N.W.2d at 722; see also *People v. Chavez*, 77 Cal. App. 2d 621, 628-29, 176 P.2d 92, 96 (1947), cited with approval in *Shephard*, 255 Iowa at 1234-35, 124 N.W.2d at 722; Lenow, *The Fetus as a Patient: Emerging Rights as a Person?*, 9 AM. J.L. & MED. 1, 4 (1983) (The *Chavez* court "noted little difference in the child a moment before or just after birth." (footnote omitted)).

143. Under this view, it is not necessary to reject the rule in these cases to impose a prebirth duty on parents when "they have reason to know that complications are likely to develop that will require hospital care." Annas, *supra* note 15, at 20. The deliberate choice of a high risk mother to have a home birth could easily be classified as gross negligence should injury to the child result. Cf. Annas, *supra* note 138, at 170.

144. See Annas, *supra* note 138, at 170; Appleton, *The Abortion-Funding Cases and Population Control: An Imaginary Lawsuit (and Some Reflections on the Uncertain Limits of Reproductive Privacy)*, 77 MICH. L. REV. 1688, 1700 nn.1-2 (1979).

One particularly interesting, albeit rather hoary, case is *Westrup v. Commonwealth*, 123 Ky. 95, 93 S.W. 646 (1906). In *Westrup*, a husband was charged with manslaughter, based upon his failure to obtain medical assistance, when his wife died as the result of a postpartum hemorrhage. The court found that she had read extensively on the subject of childbirth and had developed "a great aversion to physicians, . . . contend[ing] that they were too ready to resort in cases of childbirth to the use of instruments, which often resulted in death or injury to both mother or child." *Id.* at 98, 93 S.W. at 647. In reversing the husband's conviction, the Kentucky Court of Appeals noted that, while she may have "made a grievous mistake in adhering to her purpose of rejecting medical aid," it was clear that both husband and wife were sincere in their decision to forego the services of a physician. *Id.* at 101, 93 S.W. at 647. Indeed, the court noted the fact that "some women die in childbirth, though attended by physicians, and others without their assistance often pass through that ordeal harmless." *Id.* at 103, 93 S.W. at 648. Moreover, the court speculated that the actions of a physician, belatedly called to the scene, may have caused the woman's death. "[I]f the physician had not been sent for at all she might have lived . . . ; for who can say that the hemorrhage of which the woman died was not caused by the attempt of the physician to remove the afterbirth . . ." *Id.* at 102, 93 S.W. at 648.

145. See, e.g., *infra* Appendix notes 4, 7 & 27.

146. See Annas, *supra* note 15, at 19; Katz, *Childbirth and the Law*, 60 COLO. MED. 64, 65-66 (1980).

risk" defense would be available against the injured infant as plaintiff.¹⁴⁷

Sources and Scope of Rights and Duties

Because no laws of general application have ever imposed on parents prohibitions or duties with regard to childbirth, their constitutionality has yet to be tested.¹⁴⁸ This section examines legal rights and duties capable of significantly influencing a determination of the constitutional status of childbirth. It focuses in turn on the family, the mother, the child, the doctor and hospital, and, finally, the state.

A series of United States Supreme Court cases have acknowledged the specially protected status of the family under the Constitution.¹⁴⁹ The parameters of that status, however, remain unclear. Although there exists "a private realm of family life which the state cannot enter,"¹⁵⁰ parents may not disregard "harmful possibilities . . . of . . . physical injury" and "make martyrs of their children before . . . they can make that choice for themselves."¹⁵¹ Thus, classification of birth as an event of great social import places it squarely within that area in which the parents' autonomy is greatest, whereas if birth is characterized as a life-threatening medical procedure, the state's justification to intervene on the child's behalf is at its apex.¹⁵²

Even when the issue is one of appropriate medical care, the law begins with the presumption "that natural bonds of affection lead parents to act in the best interests of their children."¹⁵³ The general presumption

147. See Stutheit, *Discussion*, 60 COLO. MED. 68 (1980).

148. See L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-10, at 934 (1978).

149. See *Moore v. City of East Cleveland*, 431 U.S. 494 (1977); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923). See generally Keiter, *Privacy, Children, and Their Parents: Reflections On and Beyond the Supreme Court's Approach*, 66 MINN. L. REV. 459, 488-94 (1982); *Developments in the Law—The Constitution and the Family*, 93 HARV. L. REV. 1156, 1161-66 (1980) [hereinafter cited as *Developments*].

150. *Moore v. City of East Cleveland*, 431 U.S. 494, 499 (1977) (quoting *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944)).

151. *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944).

152. While nurture and value inculcation have been treated as presenting conflicts between the family unit and the state, the state has been treated as the arbiter in conflicts between parent and child in cases involving medical care. Richards, *The Individual, the Family, and the Constitution: A Jurisprudential Perspective*, 55 N.Y.U. L. REV. 1, 50 (1980); Smith, *Disabled Newborns and the Federal Child Abuse Amendments: Tenuous Protection*, 37 HASTINGS L.J. (1986); Note, *Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State*, 58 N.Y.U. L. REV. 157, 176, 184 (1983).

153. *Parham v. J.R.*, 442 U.S. 584, 602 (1979); see Note, *supra* note 152, at 188. The issue of when this presumption is overcome is discussed elsewhere in this symposium. See Shapiro & Barthel, *Infant Care Review Committees: An Effective Solution to the Baby Doe Dilemma?*, 37 HASTINGS L.J. 827.

that parents are in a better position than the state to fulfill the child's needs is directed, in effect, toward serving the child's interests.¹⁵⁴ The parents, however, have a significant interest of their own in the love and satisfaction that they derive from raising their children. This interest, at its peak at the moment of birth, is particularly strong for the mother.

Closely related to the cases addressing familial privacy are those concerning procreation,¹⁵⁵ contraception,¹⁵⁶ and abortion.¹⁵⁷ Although advocates of alternatives in childbirth extract from this web of cases a broad "right to make procreative choices,"¹⁵⁸ the decision *whether* to procreate is at least analytically, if not constitutionally, distinct from the process of birth itself.¹⁵⁹ One commentator goes so far as to suggest that once the woman has chosen to bring a child into the world, she waives her own right to bodily privacy in favor of the health of the fetus.¹⁶⁰ The logical consequences of this argument are truly staggering in that they suggest that the woman may have a constitutional obligation to avoid work, recreation, medical care, and personal habits potentially harmful to the fetus,¹⁶¹ or to submit to mandatory prenatal genetic screening¹⁶² and surgery attendant to *in utero* fetal therapy.¹⁶³

154. See Richards, *supra* note 152, at 28; *Developments, supra* note 149, at 1214, 1353-54.

155. See, e.g., *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

156. See, e.g., *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

157. See, e.g., *Roe v. Wade*, 410 U.S. 113 (1973).

158. See Comment, *A "Birth Right": Home Births, Midwives, and the Right to Privacy*, 12 PAC. L.J. 97, 103 (1980).

159. See *Fitzgerald v. Porter Memorial Hosp.*, 523 F.2d 716, 721 (7th Cir. 1975) ("The birth of a child is an event of unequalled importance in the lives of most married couples. But deciding the question of whether the child shall be born is of a different magnitude from deciding where, by whom, and by what method he or she shall be delivered."); Robertson, *Procreative Liberty and the Control of Conception, Pregnancy, and Childbirth*, 69 VA. L. REV. 405, 410 (1983).

160. See Robertson, *supra* note 159, at 438 ("The mother has, if she conceives and chooses not to abort, a legal and moral duty to bring the child into the world as healthy as is reasonably possible [T]he viable fetus acquires rights to have the mother conduct her life in ways that will not injure it."); *id.* at 442 ("Having decided to use her body to procreate, she loses the *bodily freedom* during pregnancy to harm the child." (emphasis added)); Shaw, *The Potential Plaintiff: Preconception and Prenatal Torts*, in GENETICS AND THE LAW II, at 225, 228 (A. Milunsky & G. Annas eds. 1980) ("[O]nce a pregnant woman has abandoned her right to abort and has decided to carry her fetus to term, she incurs a conditional prospective liability for negligent acts toward her fetus." (footnote omitted)). See generally Note, *Constitutional Limitations on State Intervention in Prenatal Care*, 67 VA. L. REV. 1051 (1981).

161. "Laws that prohibited pregnant women from obtaining or using alcohol, tobacco, or drugs likely to damage the fetus would be constitutional, even if these laws applied only to pregnant women." Robertson, *supra* note 159, at 442.

162. *Id.* at 447-50.

163. *Id.* at 443-47; see Ruddick & Wilcox, *Operating on the Fetus*, HASTINGS CENTER REP., Oct. 1982, at 10. In this view, the constitutional status of pregnant women reduces them

It may be unlikely that laws such as those hypothesized above would be adopted.¹⁶⁴ Nevertheless, the notion that the pregnant woman owes a special duty to the unborn child is a compelling one. One way of conceptualizing that duty is to borrow Professor Regan's analysis of *Roe v. Wade* in terms of Samaritan law.¹⁶⁵ Professor Regan makes the equal protection argument that forbidding abortion would compel the pregnant woman to be a "Good Samaritan" and shoulder significant burdens not imposed on other potential Samaritans.¹⁶⁶ He too adopts the notion that by carrying her pregnancy beyond viability the woman "has waived her right of non-involvement with the fetus."¹⁶⁷ The duties of a Samaritan, however, arise only when the person in need of rescue is in "serious peril, threatening death or great bodily harm,"¹⁶⁸ and the duty is suspended if rescue would place the Samaritan in danger.¹⁶⁹ In the context of pregnancy and birth, this formulation is perfectly compatible with the notion that liability would only attach to parents in instances of gross negligence, as when an obvious need for medical aid could be anticipated for a high risk mother or arose because of complications appearing after the onset of labor.¹⁷⁰

The legal rights of the child may also be relevant to the constitutional status of childbirth. Some opponents of home birth argue that it constitutes child abuse and neglect.¹⁷¹ Every state imposes on parents by statute a duty to provide necessary medical assistance to a helpless minor

to "baby vehicles, no longer persons in their own right, but carriers of pre-born children." Chavkin, *Woman as Baby Vehicle*, 7 WOMEN'S RTS. L. REP. 219, 219 (1982); cf. Raines, *Editorial Comment*, 63 OBSTETRICS & GYNECOLOGY 598, 599 (1984) ("The emerging rights of the unborn, where they conflict with the health and personal interests of the 'maternal host,' will present even more complex questions . . ."). For a contrary viewpoint to that expressed by Robertson, see generally Nelson, *supra* note 7.

164. See Note, *Parental Liability for Prenatal Injury*, 14 COLUM. J.L. & SOC. PROBS. 47, 85-86 (1978); see also J. ELY, *DEMOCRACY AND DISTRUST* 182 (1980).

165. See Regan, *Rewriting Roe v. Wade*, 77 MICH. L. REV. 1569 (1979).

166. *Id.* at 1569-70.

167. *Id.* at 1643.

168. See generally Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247, 292 (1980).

169. See Regan, *supra* note 165, at 1642 ("There is no other case in which we would even consider requiring one individual to sacrifice his life or health for another."). But cf. Comment, *Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue*, 31 UCLA L. REV. 252, 265 n.66, 272 n.117 (1983) (special relationship may require more than an "easy" rescue).

170. One difference between the rescue situation and cases of ordinary negligence is this: in the former cases injury is very likely. If a person *needs* help and does not receive it, he will be injured. In the latter cases, there is no definite person who is harmed (until, of course, the accident happens).

Comment, *supra* note 169, at 274 n.129. See *supra* notes 142-43 & accompanying text.

171. See, e.g., Annas, *supra* note 15, at 20.

child.¹⁷² Although the fetus is not a "person" for the purposes of the fourteenth amendment,¹⁷³ states are not barred from regarding the fetus as a "child" within the scope of abuse and neglect statutes,¹⁷⁴ or including "feticide" within homicide or wrongful death statutes.¹⁷⁵

The states are now "unanimous in recognizing that one who intentionally injures an unborn fetus may be liable in damages."¹⁷⁶ Of particular significance in this context is the possibility that the child could bring a cause of action against its parents. Although there is but one reported case of such a suit being filed,¹⁷⁷ the legal commentators unanimously agree that, with the waning of the doctrine of interfamilial immunity, an action for negligence against the mother resulting in prenatal injury is logically indistinguishable from one directed against a third party.¹⁷⁸

The concept in the leading historical case denying recovery for pre-

172. Robertson, *supra* note 141, at 218 (footnotes omitted); see Comment, *Relief for the Neglected Child: Court-Ordered Medical Treatment in Non-Emergency Situations*, 22 SANTA CLARA L. REV. 471, 473-78 (1982).

173. See *Roe v. Wade*, 410 U.S. 113, 157-58 (1973).

174. Compare *People v. Estergard*, 169 Colo. 445, 457 P.2d 698 (1969) (in pregnant woman's suit for support, court held that fetus was a "child" for purposes of neglect statute); *Jefferson v. Griffin-Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981) (state granted temporary custody of fetus under statute as deprived child in order to compel medically indicated Cesarean section); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964) (special guardian appointed for fetus to consent to blood transfusion during labor, if necessary, objected to on religious grounds by Jehovah's Witness mother); Bowes & Selgestad, *Fetal Versus Maternal Rights: Medical and Legal Perspectives*, 58 OBSTETRICS & GYNECOLOGY 209 (1981) (case study of ad hoc hearing convened in hospital while woman was in labor, finding that unborn child experiencing fetal distress was neglected within meaning of Colorado Children's Code and ordering Cesarean section) with *In re Steven S.*, 126 Cal. App. 3d 23, 178 Cal. Rptr. 525 (1981) ("child" in probate code does not apply to unborn persons); *In re Dittrick Infant*, 80 Mich. App. 219, 263 N.W.2d 37 (1977) (same as *Steven S.*).

175. See Kader, *The Law of Tortious Prenatal Death Since Roe v. Wade*, 45 MO. L. REV. 639 (1980); Note, *Torts—Wrongful Death—A Viable Fetus is a "Person" Under the New Mexico Wrongful Death Statute*: *Salazar v. St. Vincent Hospital*, 12 N.M.L. REV. 843 (1982); see also *Reyes v. Superior Court*, 75 Cal. App. 3d 214, 141 Cal. Rptr. 912 (1977) (child does not include fetus in felony child-endangering statute).

176. Robertson, *Toward Rational Boundaries of Tort Liability for Injury to the Unborn: Prenatal Injuries, Preconception Injuries and Wrongful Life*, 1978 DUKE L.J. 1401, 1402 (footnote omitted); see Doudera, *Fetal Rights? It Depends*, 18 TRIAL 38, 39 (1982).

177. *Grodin v. Grodin*, 102 Mich. App. 396, 301 N.W.2d 869 (1980) (child sued mother, alleging that she had been negligent in taking tetracycline during pregnancy, resulting in discoloration of his teeth).

178. See, e.g., Beal, "Can I Sue Mommy?" *An Analysis of a Woman's Tort Liability for Prenatal Injuries to her Child Born Alive*, 21 SAN DIEGO L. REV. 325 (1984); Robertson, *supra* note 159, at 441-42; Note, *supra* note 164; Note, *Recovery for Prenatal Injuries: The Right of a Child Against Its Mother*, 10 SUFFOLK U.L. REV. 582 (1976).

natal injury,¹⁷⁹ that the mother and fetus are a single entity, has long been discredited in legal precedent.¹⁸⁰ Plainly, in many situations the actions of the mother are at odds with the interests of the unborn child: she may be employed in a workplace in which teratogenic substances are prevalent;¹⁸¹ her religious beliefs may forbid life-saving blood transfusions;¹⁸² she may refuse a Cesarean section in the face of an acute, life-threatening emergency;¹⁸³ or she may elect to abort her pregnancy. Equating such conflicts with the choice of home birth or other alternatives in childbirth presupposes the very interest in dispute, that these choices deny necessary medical care for the child to its detriment.

The physician-patient relationship is one to which the courts have paid extraordinary deference. Although the decision in *Roe v. Wade*¹⁸⁴ is commonly cited for the proposition that the right of privacy protects a woman's decision to abort her pre-viable pregnancy, no mention of that right was made by Justice Blackmun in the concluding summary of his opinion. Rather, he stated that "[t]he decision vindicates the right of the physician to administer medical treatment according to his professional judgment."¹⁸⁵ Subsequent abortion decisions have emphasized repeatedly the importance of not interfering with the physician-patient relation-

179. *Dietrich v. Northampton*, 138 Mass. 14 (1884) (Holmes, J.).

180. Kader, *supra* note 175, at 647 and cases cited therein. *But compare* Lenow, *supra* note 142, at 2 ("Fundamental . . . is the issue of whether the mother and the fetus are a single biologic entity or two distinct patients The possibility of maternal-fetal conflict grows as obstetrical advances in fetal care continue.") with Hubbard, *Legal and Policy Implications of Recent Advances in Prenatal Diagnosis and Fetal Therapy*, 7 WOMEN'S RTS. L. REP. 201, 215 (1982) ("It makes no sense, biologically or socially, to pit fetal and maternal rights against one another As long as they are connected, nothing can happen to one that does not affect the other To argue "rights" of the fetus *versus* those of the mother ignores this organic unity and substitutes a false dichotomy, though one that is habitual in western, mechanistic thought, in which we speak of head *vs.* heart, hand *vs.* brain, and mind *vs.* body.").

181. See Rothstein, *Employee Selection Based on Susceptibility to Occupational Illness*, 81 MICH. L. REV. 1379, 1460-65 (1983); Williams, *Firing the Woman to Protect the Fetus: The Reconciliation of Fetal Protection with Employment Opportunity Goals Under Title VII*, 69 GEO. L.J. 641 (1981).

182. See *Application of President of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *Raleigh Fitkin-Paul Morgan Memorial Hosp.*, 42 N.J. 421, 201 A.2d 437, *cert. denied*, 377 U.S. 985 (1964); *Hoener v. Bertinato*, 67 N.J. Super. 517, 171 A.2d 140 (1961).

183. See, e.g., Jurow & Paul, *Cesarean Delivery for Fetal Distress Without Maternal Consent*, 63 OBSTETRICS & GYNECOLOGY 596 (1984); see generally Nelson, *supra* note 7.

184. 410 U.S. 113 (1973).

185. *Id.* at 165 (emphasis added); see also *Doe v. Bolton*, 410 U.S. 179, 195-200 (1973) (Statutes requiring abortion committee approval or two physicians' concurrence to perform abortion interfere with exercise of physician's "best clinical judgment" on behalf of his patient.).

ship.¹⁸⁶ Hence the suggestion that "the decision in *Roe* gave the physician the most rights in the doctor-patient-state triangle."¹⁸⁷

The essence of the conflict between the social and medical perspectives of birth is the characterization of the birth process itself. Adherents of alternatives in childbirth argue that, for the vast majority of women, birth is a normal function rather than a medical event.¹⁸⁸ Proponents of the medical perspective, on the other hand, point to the serious risks inherent in the process and, consequently, the importance of medical science in limiting these risks.¹⁸⁹ The courts generally have adopted the view of the medical profession.

In *Fitzgerald v. Porter Memorial Hospital*,¹⁹⁰ the court rejected the plaintiffs' argument that the right of marital privacy included the right of the husband to be present in the delivery room.¹⁹¹ Judge (now Justice) Stevens, writing for the court, observed that "[i]n its medical aspects, the obstetrical procedure is comparable to other serious medical procedures," and parents are in no different position than "other individuals in need of *extraordinary* medical assistance."¹⁹² In this particular instance, although the wife's obstetrician consented to the husband's presence, hospital rules prohibited it. Noting that the parents did not argue for such a right without physician consent, the court reasoned that "[i]mplicitly, therefore, they acknowledge that their asserted right is subordinate to the dictates of sound medical practice."¹⁹³ Having thus reduced the legal issue to one of medical judgment, the court concluded that it would be inappropriate to substitute its judgment for the profes-

186. See, e.g., *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 447 (1983) ("[I]n *Roe* and subsequent cases we have stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out." (quoting *Colautti v. Franklin*, 439 U.S. 379, 387 (1979))).

187. Book Note, 82 MICH. L. REV. 713, 714 (1984) (reviewing B. MILBAUER, *THE LAW GIVETH . . . LEGAL ASPECTS OF THE ABORTION CONTROVERSY* (1983)).

188. See, e.g., *Infant Mortality*, *supra* note 71, at 26 (report of Women's Health Project); D. STEWART, *supra* note 24, at 34.

189. See B. ROTHMAN, *supra* note 52, at 133-35; *supra* notes 76, 102-05 & accompanying text.

190. 523 F.2d 716 (7th Cir. 1975).

191. *Id.* at 721.

192. *Id.* (emphasis added). Ironically, although the serious medical nature of birth is asserted as an argument for all births taking place in hospitals, courts have rejected suits brought by women turned away by hospitals while in labor on the ground that they were *not* emergency patients entitled to admission. See *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd*, 542 F.2d 573 (5th Cir. 1976); *Hill v. Ohio County*, 468 S.W.2d 306 (Ky. 1970), *cert. denied*, 404 U.S. 1041 (1972).

193. *Fitzgerald*, 523 F.2d at 721; see L. TRIBE, *supra* note 148, § 15-10, at 934.

sional judgment of the hospital staff.¹⁹⁴

Theoretically, although hospital patients may not insist that a particular mode of treatment be administered, if competent they may refuse any medical procedure.¹⁹⁵ Nevertheless, in the context of birth, physicians have asserted that they have *two* patients—the mother and the child—and that they owe a duty of care to the latter that cannot be refused by the former.¹⁹⁶ This argument has been particularly controversial in cases in which mothers have refused Cesarean sections that their physicians insisted were necessary to save the life of the fetus. Several such instances have been reported.¹⁹⁷ While in some cases the operation may indeed have been necessary to save the life of the fetus,¹⁹⁸ in others diagnoses have proved to be mistaken.¹⁹⁹ The errors in those cases might be regarded as particularly noteworthy because the physicians involved were so certain of their pessimistic diagnoses that they took the extreme and unusual step of seeking a court order compelling surgical delivery.

The legal precedent invoked in these cases is of two categories, neither of which withstands close scrutiny. The first category, involving court-ordered blood transfusions for Jehovah's Witnesses,²⁰⁰ entails an insignificant bodily invasion compared with Cesarean surgery.²⁰¹ Moreover, although the Witnesses refused on religious grounds to *consent*, they generally expressed a willingness to *accede* to the court's authority if

194. *Fitzgerald*, 523 F.2d at 721.

195. See Annas, *supra* note 138, at 176. See generally G. ANNAS, L. GLANTZ & B. KATZ, *THE RIGHTS OF DOCTORS, NURSES AND ALLIED HEALTH PROFESSIONALS* 71-97 (1981) [hereinafter cited as G. ANNAS].

196. See, e.g., Bowes & Selgestad, *supra* note 174, at 213; Raines, *supra* note 163, at 404; Stutheit, *supra* note 147, at 68. Robertson has argued that, in contracting with the physician for treatment, the parents create a non-extinguishable duty running from the doctor to the infant as a third-party beneficiary of that contract. Robertson, *supra* note 141, at 226-27; see *Hughson v. St. Francis Hosp.*, 92 A.D.2d 131, 459 N.Y.S.2d 814 (1983) (infant born alive possesses independent cause of action against physician for prenatal injuries arising out of failure to obtain informed consent of mother).

197. See Annas, *Forced Cesareans: The Most Unkindest Cut of All*, HASTINGS CENTER REP., June 1982, at 16 (legally compelled Cesarean sections); Luce, *supra* note 112, at 243-44 (example of "coerced" Cesarean section).

198. Jurov & Paul, *supra* note 183, at 598.

199. In *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981), the medical testimony on which the court based its order that a Cesarean section be performed was that an attempted vaginal delivery posed a 99% likelihood of fetal death and at least a 50% chance of maternal death. *Id.* at 86, 274 S.E.2d at 458. A few days later, however, the mother "uneventfully delivered a healthy baby without surgical intervention." Annas, *supra* note 197, at 16; see also Bowes & Selgestad, *supra* note 174, at 211.

200. See *Application of President of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

201. See Annas, *supra* note 197, at 17.

it relieved them of their moral responsibility by ordering the transfusion.²⁰² The second category of cases involves court-ordered organ transplants from incompetents.²⁰³ While cited for the proposition that surgery may be ordered on one individual to allow another to live,²⁰⁴ the cases were decided on an entirely different rationale. Invoking the doctrine of "substituted judgment," the courts permitted the transplants based on their conclusion that the donors themselves would have wished to consent had they been competent to do so.²⁰⁵ In the context of forced Cesarean sections, however, no such judgment is appropriate, since competent adults have unequivocally refused to give their consent.²⁰⁶

Two other situations may be relevant to the question of compelled medical treatment in normal childbirth. The first is the notion that, as strides are made in the development of *in utero* fetal therapy, there arises a corresponding "right of treatment" for the fetus.²⁰⁷ The second involves an analogy to cases in which parents have desired to pursue alternative forms of treatment for seriously ill children. In *In re Hofbauer*,²⁰⁸ the court permitted the parents to follow a course of "metabolic therapy" in the treatment of their son's leukemia, *subject to* medical supervision and application of conventional chemotherapy should his condition worsen. In contrast, in the more highly publicized case of Chad Green, the Massachusetts Supreme Court rejected a similar course of treatment when the parents displayed an unwillingness to defer to medical authority.²⁰⁹

202. See Application of President of Georgetown College, 331 F.2d 1000, 1009 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

203. See Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Conn. Super. Ct. 1972); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969). See generally Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

204. See Bowes & Selgestad, *supra* note 174, at 212-13.

205. See Hart v. Brown, 29 Conn. Supp. 368, 370-71, 375, 377-78, 289 A.2d 386, 387-88, 389, 390-91 (Conn. Super. Ct. 1972); Strunk v. Strunk, 445 S.W.2d 145, 148 (Ky. 1969).

206. See Lenow, *supra* note 142, at 19-20; Robertson, *supra* note 203, at 76 ("[T]he substituted judgment doctrine is explicitly non-utilitarian, and makes no claim that the rights of incompetents may be overridden to advance the rights of others For it seeks to treat incompetents . . . as creatures of choice . . . whose choices as best as we can ascertain them are to be respected.").

207. See Hubbard, *supra* note 180, at 217 ("[W]omen soon may not have the right to refuse prenatal interventions. The expanded repertory of prenatal technologies may enable obstetricians . . . to force women to become patients.'"); Lenow, *supra* note 142, at 22-27. See generally Nelson, *supra* note 7.

208. 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979).

209. Custody of a Minor, 378 Mass. 732, 393 N.E.2d 836 (1979); see Note, *Of Love and Laetrile: Medical Decision Making in a Child's Best Interests*, 5 AM. J.L. & MED. 271 (1979). Violating the court's order compelling chemotherapy, the Greens took their son to Mexico, where he died on Oct. 12, 1979. *Id.* at 271-72 n.1.

Arguments asserted as a basis for overriding maternal opposition to medical treatment during pregnancy and birth represent a unique negation of the concept of informed consent. They are based in part on a notion that if the mother manifests disagreement with the course of treatment advised by the physician, such disagreement must be based on ignorance or stubbornness and somehow obviates the necessity to obtain consent.²¹⁰ Analogizing once again to the concept of Samaritan law, even if the argument is accepted that obstetrical procedures, including Cesarean sections, represent an "insignificant" imposition on the mother and entail little physical risk,²¹¹ a good faith fear of the dangers posed would legally excuse a duty to rescue.²¹²

These arguments also assume that choice of treatment is always an essentially *medical* decision. This assumption was thoughtfully considered in a series of articles in the *American Journal of Law and Medicine* discussing standards for withholding or discontinuing life-prolonging treatment for incompetent terminally ill patients. Dr. Arnold Relman, editor of the *New England Journal of Medicine*, criticized judicial interference with the medical tradition that such judgments were best left to the physician.²¹³ In response, both Charles Baron, a law professor, and Allen Buchanan, a philosophy professor, rejected the notion that such decisions, although they involved choices concerning medical treatment, were in themselves medical.²¹⁴ A similar argument about such decisions is made by advocates of alternatives in childbirth—that they present so-

210. See, e.g., Lieberman, Mazor, Chaim & Cohen, *The Fetal Right to Live*, 53 OBSTETRICS & GYNECOLOGY 515 (1979) [hereinafter cited as Lieberman]; Raines, *supra* note 163, at 598 ("The refusal of a particular procedure establishes with the physician the duty to suggest alternative approaches; however, if alternatives are not feasible, and if the patient refuses care in the face of a pressing need for it, this may be evidence of incompetence." (footnote omitted)).

211. See, e.g., Robertson, *supra* note 159, at 456-57.

212. See Shriner, *Maternal Versus Fetal Rights—A Clinical Dilemma*, 53 OBSTETRICS & GYNECOLOGY 518, 519 (1979); Comment, *supra* note 169, at 274-75 n.135.

213. Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978).

214. Clearly the question of what course of treatment a patient wishes for himself is not "medical" in the sense in which questions regarding diagnosis and prognosis are "medical." What makes it difficult to keep these types of questions separate in practice, however, is the ease with which doctors move into one kind of question from the other in a way which muddles the distinction between them and covertly makes a decision for a patient.

Baron, *supra* note 6, at 341. "[T]hese are not medical decisions; they are *moral* decisions of the most fundamental sort. They are basic judgments about what we ought or ought not to do, and though they are based in part on judgments about medical facts, they are in no way reducible to the latter." Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases*, 5 AM. J.L. & MED. 97, 102 (1979).

cial, economic, and political, rather than merely medical, issues.²¹⁵

Finally, the emphasis on standard obstetric care, fetal rights, and maternal waiver ignores countervailing obligations of a legal and professional nature. The doctor's ultimate legal duty clearly is to the *mother*, rather than the fetus, if their interests must be regarded as dichotomous. In *Colautti v. Franklin*,²¹⁶ the United States Supreme Court struck down a state statute requiring that in the performance of post-viability abortions the physician use the method "which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother."²¹⁷ The district court heard extensive testimony that indicated that this provision would require delivery by Cesarean section and subject the mother to the attendant risks of surgery.²¹⁸ Writing for the Court, Justice Blackmun concluded that the statute must be struck down because it did not "clearly specify . . . that the woman's life and health must always prevail over the fetus' life and health when they conflict."²¹⁹ He regarded it as potentially "requir[ing] the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties . . . lurk behind this ambiguity."²²⁰

The state's power to regulate birth settings and attendants derives from two distinct sources: the police power and the *parens patriae* power. The police power encompasses the authority of the state to promote public health, safety, morals, or general welfare.²²¹ The *parens patriae* power is the state's limited power to act in a capacity protective of individuals incapable of acting in their own best interests.²²² The latter power is limited because its exercise must be particularized to the welfare

215. See, e.g., Stanwick, *You Mean We Still Have Midwives?*, MOTHERING, Winter 1977, at 61; *supra* note 112 & accompanying text; see also Gillespie, *supra* note 22, at 47; Salmon & Berliner, *supra* note 22, at 547.

216. 439 U.S. 379 (1979).

217. *Id.* at 397 (quoting Pennsylvania Abortion Control Act, 1974 Pa. Laws Act No. 209, § 5(a)).

218. *Colautti*, 439 U.S. at 398-99.

219. *Id.* at 400. Moreover, the Court has emphasized that in the context of birth, "health" considerations encompass "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient." *Doe v. Bolton*, 410 U.S. 179, 192 (1973).

220. *Colautti*, 439 U.S. at 400; see also American College of Obstetricians & Gynecologists v. Thornburgh, 737 F.2d 283, 300-01 (3d Cir. 1984), *aff'd*, 106 S. Ct. 2169 (1986).

221. *Village of Euclid v. Ambler Realty Co.*, 272 U.S. 365, 395 (1926); see *Jacobson v. Massachusetts*, 197 U.S. 11, 20, 25, 30-31 (1905) (Court held that vaccination law was a valid exercise of police power).

222. *Developments*, *supra* note 149, at 1199.

of the particular individual at risk.²²³ The extent to which the state may or must exercise these powers to determine the ultimate arbiter of which settings, attendants, and techniques are permissible in childbirth depends in part on whether childbirth is a fundamental right under the Constitution.

Childbirth and the Constitution

If childbirth is entitled to constitutional protection as a fundamental right, a law or regulation that infringes upon the exercise of that right must be narrowly drawn to serve a compelling state interest and will be carefully scrutinized by the courts. By contrast, if childbirth is not entitled to such protection, a law or regulation affecting it will be subject only to the limited "rational basis" test. This section considers whether alternative birth choices, including attendance by an unlicensed practitioner, are fundamental rights. Assuming, as this Article concludes, that such choices are not constitutionally protected from state regulation, either because they are not fundamental rights or because a substantial government interest is present, this section proceeds to a rational basis analysis of the issues presented.

Several commentators have relied on the "right of privacy" to argue that the choice of alternative modes of childbirth is a fundamental right.²²⁴ While the United States Supreme Court has discussed associated concerns such as marriage, procreation, the family, and child-rearing under the rubric of "privacy,"²²⁵ the Court has not defined privacy in such a way that any particular activity which logically might be said to fall within these general spheres can necessarily be identified as "fundamental."²²⁶

"Privacy" analysis of childbirth alternatives must begin with the abortion decisions. The cases decided by the Court in 1983 suggest that state laws requiring hospital or doctor-attended births would not violate the Constitution. In *City of Akron v. Akron Center for Reproductive*

223. *Id.*

224. See, e.g., Caldwell, *supra* note 136, at 28; Comment, *A Matter of Quality of Births: Mothers and Midwives Shackled by the Medical Establishment and Pennsylvania Law*, 23 DUQ. L. REV. 171, 192-94 (1984); Note, *supra* note 5, at 682-97; Comment, *supra* note 158, at 103-08.

225. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 386 (1978); *Roe v. Wade*, 410 U.S. 113, 152-53 (1973); see also *supra* notes 155-58 & accompanying text.

226. See Henkin, *Privacy and Autonomy*, 74 COLUM. L. REV. 1410, 1426, 1431 (1974); Note, *Fornication, Cohabitation, and the Constitution*, 77 MICH. L. REV. 252, 259-60, 266-67 (1978).

Health,²²⁷ the Court acknowledged the state's legitimate interest in regulating the type of facility in which second-trimester abortions can be performed, but held that it was constitutionally impermissible to impose the burdensome requirement that all such abortions be performed in a hospital when there was "impressive evidence" that outpatient procedures in the early weeks of the second trimester were equally safe.²²⁸ In *Planned Parenthood v. Ashcroft*,²²⁹ the Court held invalid under the *Akron* analysis a Missouri statute requiring hospitalization for second-trimester abortions, but upheld a statute requiring the presence of a second physician during abortions performed after viability, despite the fact that "Missouri does not require two physicians in attendance for any other medical or surgical procedure, including childbirth or delivery of a premature infant."²³⁰ In *Simopoulos v. Virginia*²³¹ the Court distinguished *Akron* in upholding a state statute requiring that abortions after the first trimester be performed in state-licensed "hospitals," which the Court interpreted as encompassing not only full-service but also outpatient surgical hospitals.²³²

In each of these cases, the Court attempted to strike a balance between the woman's right to choose a particular course of medical treatment and the state's interest in maternal health or the potential health of the fetus. The cases suggest that the Court might uphold state laws requiring hospital and doctor-attended births or otherwise diminishing choice in childbirth procedures if the Court deemed the alternative procedures inadequate to protect those interests.

Proponents of childbirth alternatives argue that the abortion cases are distinguishable because, unlike abortion, normal childbirth is not a medical procedure.²³³ However, the proviso to this effort to distinguish the abortion cases, that childbirth is a "normal" procedure, raises the practicability of low-risk prenatal screening²³⁴ and the social/medical/legal conundrum of risk assessment²³⁵ to constitutional significance.²³⁶ Privacy arguments, to the extent they rely on the rationale that the acts

227. 462 U.S. 416 (1983).

228. *Id.* at 437.

229. 462 U.S. 476 (1983).

230. *Id.* at 484-85.

231. 462 U.S. 506 (1983).

232. *Id.* at 512-15. The Court distinguished *Ashcroft*, 462 U.S. at 481-82, and *Akron*, 462 U.S. at 433-39, on the ground that the statutes struck down in those cases required that all second-trimester abortions be performed in "general, acute-care facilities." *Simopoulos*, 462 U.S. at 516 (quoting *Ashcroft*, 462 U.S. at 481).

233. See, e.g., Cumings, *supra* note 116, at 595; Comment, *supra* note 158, at 111-12.

234. See *supra* notes 37-42 & accompanying text.

235. Cf. Note, *supra* note 152, at 186-88 (relationship of a child's condition to state inter-

for which constitutional protection is advocated are personal and do not affect others, are inapposite to the issue of childbirth.²³⁷ In the context of childbirth, while the potential harm or benefit to the child of a particular circumstance of its birth may be disputed, the child is nonetheless a third person directly affected by the choice in question.

Other bases upon which proponents have asserted that alternatives in childbirth are fundamental rights are unpersuasive. One argument is that the Constitution protects "personal lifestyles,"²³⁸ either within the right of privacy or as "expression" under the first amendment, and that such protection encompasses alternative childbirth. The Supreme Court, however, has never described the right of privacy in this way. Nor is alternative childbirth "speech," in that it expresses only a preference for alternative childbirth.²³⁹ Similarly, although the argument has been made that birth is a "spiritual" event,²⁴⁰ thus falling within the religion clause of the first amendment,²⁴¹ alternative childbirth would not be entitled to constitutional protection unless it were an established part of a coherent religious belief.²⁴²

Finally, the argument has been made that home birth may be a residual right encompassed by the ninth amendment.²⁴³ Since tradition

est in compelled medical treatment cases). See generally Huber, *Safety and the Second Best: The Hazards of Public Risk Management in the Courts*, 85 COLUM. L. REV. 277 (1985).

236. See *Akron*, 462 U.S. 416. One commentator has cited *Akron* for the proposition that it is unconstitutional to restrict access to CNM attendants when only some women require the presence of a physician during labor and delivery. Note, *supra* note 5, at 703. This argument ignores the fact that the line drawn in *Akron* at approximately the 16th week of pregnancy is an objective one of general applicability. *Akron* strikes down the hospitalization requirement for *all* second-trimester abortions. It does not hold that, once an objectively reasonable line has been drawn, it would be unconstitutional to apply the hospitalization requirement to women of longer than 16 weeks' gestation who asserted on the basis of "preabortion screening" that an outpatient procedure would be safe in their case.

237. Cf. Note, *supra* note 113, at 826 (distinction between self-regarding and other-regarding actions).

238. Wilkinson & White, *Constitutional Protection for Personal Lifestyles*, 62 CORNELL L. REV. 563 (1977).

239. Cf. *Clark v. Community for Creative Non-Violence*, 104 S. Ct. 3065, 3069 n.5 (1984) (rejecting rule that all conduct is presumptively expressive). To the extent that alternative childbirth might be chosen for purely symbolic reasons, it would be subject to reasonable time, place, and manner restrictions, and undoubtedly to direct regulation as well, given that obviation of risk to mother and fetus would constitute a substantial government interest unrelated to the suppression of free speech. See *id.* at 3069.

240. See generally I. GASKIN, *supra* note 27.

241. See Solares, *Midwifery Licensing: Pitfalls, Problems and Alternatives to Licensing*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 399, 423 (D. Stewart & L. Stewart eds. 1979); see also Raymond, *supra* note 20, at 197.

242. *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972); *State v. Chambers*, 144 Vt. 234, 238, 477 A.2d 110, 112 (1984).

243. See *Griswold v. Connecticut*, 381 U.S. 479, 486-87 (1965) (Goldberg, J., concurring)

is of some relevance in defining what constitutes a fundamental right,²⁴⁴ it is arguably significant that home birth has never been subject to legal restriction.²⁴⁵ However, just as the Court has given up its short-lived attempt under the tenth amendment to carve out a realm of "state qua state" activity immune from federal regulation,²⁴⁶ it is unlikely to recognize a uniquely personal act such as home birth as a right somehow inherent or reserved to the individual.²⁴⁷

The right to choose alternative modes of childbirth is largely dependent on the availability, and hence legalization, of midwives. If that right is fundamental, then arguably prohibitions on the practice of midwifery would constitute unreasonable barriers to its exercise.²⁴⁸ If, however, it is not, then the constitutionality of such prohibitions would depend upon whether midwives themselves had some fundamental right to practice.

Regulation and licensure of persons practicing the "healing arts" is a legitimate interest of the state.²⁴⁹ Nevertheless, supporters of midwifery argue that health care is a basic right and encompasses the right to choose a midwife attendant.²⁵⁰ In particular instances, courts have held that the state cannot foreclose the individual's reasonable choice of practitioner or treatment.²⁵¹ For example, in *Akron*, the Court held that the state could not require counselors, who were required by law to obtain the informed consent of abortion patients, to have a medical degree.²⁵² And in *Andrews v. Ballard*²⁵³ a federal district court struck

(right of privacy a fundamental personal right "retained by the people" within the meaning of the ninth amendment).

244. See *Developments*, *supra* note 149, at 1178-79; Note, *supra* note 226, at 267-69.

245. See *supra* note 137 & accompanying text.

246. *Garcia v. San Antonio Metropolitan Transit Auth.*, 105 S. Ct. 1005 (1985) (overruling *National League of Cities v. Usery*, 426 U.S. 833 (1976)).

247. Moreover, the abortion cases have explicitly linked the scope and even the existence of the woman's privacy right to the state of contemporary medical knowledge and techniques. See *Roe v. Wade*, 410 U.S. 113, 149 (1973).

248. But see *Bowland v. Municipal Court*, 18 Cal. 3d 479, 495, 556 P.2d 1081, 1089, 134 Cal. Rptr. 630, 638; cf. *Carnohan v. United States*, 616 F.2d 1120, 1121 (9th Cir. 1980) (*per curiam*) (constitutional right to treat oneself with home remedies would not entitle individual to obtain laetrile free of government regulation).

249. See *England v. Louisiana State Bd. of Medical Examiners*, 259 F.2d 626, 629-33 (5th Cir. 1958) (Wisdom, J., dissenting), *cert. denied*, 359 U.S. 1012 (1959); Annas, *Childbirth and the Law: How to Work Within Old Law, Avoid Malpractice, and Influence New Legislation in Maternity Care*, in 2 21ST CENTURY OBSTETRICS NOW! 557, 559 (L. Stewart & D. Stewart eds. 1977).

250. See, e.g., *Midwifery Hearings*, *supra* note 17, at 8 (testimony of Judy Norsigian, National Women's Health Network); *Naturopath Denied Right to Assist in Childbirth*, MOTHERING, Winter 1978, at 50.

251. See *England v. Louisiana State Bd. of Medical Examiners*, 259 F.2d 626, 627 (5th Cir. 1958) (*per curiam*), *cert. denied*, 359 U.S. 1012 (1959).

252. *Akron*, 462 U.S. at 446-49.

down a state law limiting the practice of acupuncture to licensed physicians.²⁵⁴ Both cases, however, are distinguishable in the context of childbirth. In *Akron*, the fundamental right to have an abortion was clearly established, and the Court noted that it had been presented with no evidence that qualified nonphysician counselors could not perform the counseling function.²⁵⁵ In *Andrews*, the court, in holding that the right of privacy encompasses choice of treatment, emphasized that "one's health is a uniquely personal possession," as is the decision how to treat that possession.²⁵⁶ However, the predominant view is that the right of privacy does not extend to the choice of an unlicensed practitioner,²⁵⁷ and thus statutes restricting this choice will be upheld if a rational basis underlies their enactment.

The rational basis argument for permitting midwife-attended home births is that a well-planned home birth with medical back-up is within acceptable bounds of safety and no identifiable government interest is served by placing legal restrictions on midwives while physician-attended home births are unrestricted. The argument is at its weakest with respect to physician-attended home births. Proponents of birth alternatives contend that doctors, unlike midwives, are neither trained nor skilled at facilitating normal birth in a nonhospital setting.²⁵⁸ However, although few doctors may be willing and available to perform home births,²⁵⁹ those that do so share the views of proponents of childbirth alternatives.²⁶⁰ Although their medical training may not prepare them for noninterventive obstetrics in the home, they are little different in this respect from

253. 498 F. Supp. 1038 (S.D. Tex. 1980).

254. *Id.* at 1048, 1051-52.

255. *Akron*, 462 U.S. at 448-49.

256. *Andrews*, 498 F. Supp. at 1047. Hence, the court was relying in part on the self-regarding actions rationale for extending the right of privacy. See *supra* note 237 & accompanying text.

257. See, e.g., *Connecticut v. Menillo*, 423 U.S. 9, 11 (1975) (per curiam); *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir.) ("[T]he decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health."), *cert. denied*, 449 U.S. 937 (1980).

258. See, e.g., D. STEWART, *supra* note 24, at 25, 33; Krajick, *supra* note 23, at 17; White & Eisenstadt, *The American College of Home Obstetrics (ACHO): Philosophy and Practice of Physicians in Homebirth*, in 2 21ST CENTURY OBSTETRICS NOW! 359, 369-70 (L. Stewart & D. Stewart eds. 1977) [hereinafter cited as *ACHO*]; Wilson, Stewart & Epstein, *Childbirth at Home*, 25 MED. TRIAL TECH. Q. 195, 196 (1979).

259. See Hurzeler, *Use of the Certified Nurse-Midwife in the Education of the Lay-Midwife*, J. NURSE-MIDWIFERY, May 1981, at 57.

260. See, e.g., *ACHO*, *supra* note 258.

most beginning lay midwives.²⁶¹

Proponents of home birth also could argue that, even if the right to choose alternative modes of childbirth is not fundamental, it is of such significance that restrictions on such choices should be subject to greater scrutiny than the rational basis test affords.²⁶² An analogy might be drawn to the situation in which the state seeks to compel medical treatment for children. Professor Joseph Goldstein has argued that in such situations courts should presume family autonomy and family privacy and should not interfere with the parents' choice of treatment except in a few "life-or-death" cases.²⁶³ Because of the numerous uncertainties surrounding medical prognosis, the state could overcome this presumption only if death were the likely consequence of a particular treatment choice.²⁶⁴ An analogous argument could be made for governmental intrusion into family privacy in childbirth decisions. Given the inconclusive evidence respecting the relative safety of conventional and alternative childbirth, one could argue that the choice should be left to the family, and society should tolerate the possibility of a few bad outcomes to protect the liberty of all.²⁶⁵ The difficulty with this analogy is that birth does not fit well into the "life-or-death" dichotomy on which Goldstein's formulation is based. The possibility of a birth resulting in death or serious morbidity, while small, is omnipresent.

The shortcoming of a purely constitutional approach to childbirth is that it attempts to use fundamental rights to "trump" legitimate medical and social concerns. Rights should not be "absolute possessions that individuals may exercise at their discretion . . . to exercise sovereignty over a dispute."²⁶⁶ Rights are relative, contingent upon situations.²⁶⁷ In the context of childbirth, the rights approach is capable of dividing rather

261. See generally S. ARMS, *supra* note 3, at 244-46 (country doctors describing beginning of home birth practice as "learning by doing").

262. See *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 102-03 (1973) (Marshall, J., dissenting) ("As the nexus between the specific constitutional guarantee and the non-constitutional interest draws closer, the nonconstitutional interest becomes more fundamental and the degree of judicial scrutiny applied when the interest is infringed . . . must be adjusted accordingly."); *Wensel v. Washington*, Civ. No. 11004-74 (Super. Ct. D.C. Apr. 10, 1975), *reprinted in* *Lewis v. District of Columbia Comm. on Licensure to Practice the Healing Arts*, 385 A.2d 1148, 1159-60 (D.C. 1978).

263. Goldstein, *Medical Care for the Child at Risk: On State Supervision of Parental Autonomy*, 86 YALE L.J. 645, 648-51 (1977).

264. *Id.* at 652, 653, 664.

265. See Annas, *supra* note 197, at 45.

266. Churchill & Simon, *Abortion and the Rhetoric of Rights*, HASTINGS CENTER REP., Feb. 1982, at 9, 10.

267. Fletcher, *Knowledge, Risk, and the Right to Reproduce*, in *GENETICS AND THE LAW II*, at 131, 133 (A. Milunsky & G. Annas eds. 1980).

than uniting the family.²⁶⁸ In the words of one commentator, "[T]he legitimate interests of neither child nor parents [should be] sacrificed for some *principle* which cannot legitimately claim to dominate the issue."²⁶⁹ The problem of choices in childbirth is not susceptible to any absolute ordering of priorities. Rather, what is needed is a policy-oriented approach capable of mediating competing perspectives to the greatest extent possible.

Alternatives in Childbirth—A Policy Analysis

The Objective: Maximizing Choice, Minimizing Risk

Although many parents desiring a home birth would prefer a doctor or other qualified person in attendance,²⁷⁰ when forced to choose between a hospital birth and an inadequately attended home birth, they frequently opt for the latter.²⁷¹ Policies prohibiting the practice of lay midwives by law, or allowing them to practice without regulation or oversight, increase the degree of risk associated with home birth by forcing home births underground.²⁷²

This Article advocates maximizing choice while minimizing risk. Ideally, the mainstream medical establishment would acknowledge the trend toward home birth and provide essential back-up and ancillary care.²⁷³ Suitably qualified attendants, whether doctors, certified nurse-midwives, or lay midwives, would be available in sufficient supply to assist all home births and provision would be made for training programs and oversight of lay midwives. Cooperation would be fostered between parents, physicians, and nurse and lay midwives. Such cooperation would include the availability of medical back-up, the encouragement of hospitalization in emergency situations, and the encouragement of open

268. See Schneider, *Moral Discourse and the Transformation of American Family Law*, 83 MICH. L. REV. 1803, 1858-59 (1985).

269. Finch, *supra* note 115, at 995 (emphasis in original).

270. See, e.g., Anderson, *supra* note 19, at 44.

271. R. KRAMER, *supra* note 58, at 139; Davis, *The Making of an Educated Lay Midwife and My Encounter with the Law*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 603, 607 (D. Stewart & L. Stewart eds. 1979); see Bunai, *supra* note 33, at 60; *supra* notes 44-45 & accompanying text.

272. See, e.g., Hunter, *supra* note 44, at 72; Ventre, *The Making of a Legalized Lay Midwife*, 3 BIRTH & FAM J. 109, 109 (1976); *Midwifery is Disputed*, N.Y. Times, July 12, 1981, at 40, col. 1.

273. See M. CONKLIN, *supra* note 17, at 60-61; Adamson & Gare, *supra* note 35, at 1736; Stewart, Galloway & Goodman, *An In-Hospital Birthing Room: One Year's Experience*, in 1 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 215, 218 (D. Stewart & L. Stewart eds. 1979).

communication resulting in the sharing of knowledge and skills.²⁷⁴

This ideal situation is attainable. There are indications that a similar model is evolving in the treatment of Jehovah's Witnesses. One commentator describes this phenomenon as follows:

Rather than consider the Witness patient a problem, more and more physicians accept the situation as a medical challenge. In meeting the challenge they have developed a standard of practice for this group of patients that is accepted at numerous medical centers around the country. These physicians are at the same time providing care that is best for the patient's total good.²⁷⁵

The analogy to the alternative birth movement is striking²⁷⁶ and doctors would do well to apply the same approach in the home birth context.

Meeting Unmet Needs

There is a shortage of qualified attendants willing to attend home births.²⁷⁷ This shortage could be eliminated by the use of lay midwives. Midwifery is a skill that may be taught and practiced separately from the profession of nursing.²⁷⁸

Cost has become a predominant concern of the health care delivery system. The use of midwives²⁷⁹ and alternative settings and modes of childbirth²⁸⁰ can result in direct cost savings. Indirect savings can also be

274. See WASHINGTON DEBATE, *supra* note 92, at 37 ("[T]he key element is that midwives are accepted by the health community and have ready access to all of the services necessary to the proper care of pregnant women and infants. . . . [T]he underlying issues in the current midwifery debate have more to do with psychological acceptance than with the feasibility of establishing a regulatory program that will produce competent midwives.").

275. Dixon & Smalley, *Jehovah's Witnesses: The Surgical/Ethical Challenge*, 246 J. A.M.A. 2471, 2472 (1981).

276. See *id.* at 2471-72 (Witness numbers are increasing; doctors often have refused to treat Witnesses; studies have indicated that major surgery without blood transfusions can be performed at an acceptably low level of risk; Witnesses accept responsibility for their treatment decisions, relieving doctors of liability; Witnesses seek good care for their children, and believe in the importance of family privacy and treating the whole person; and doctors have learned new and valuable surgical techniques in accommodating the needs and wishes of their patients.).

277. There are also medically underserved areas where midwives—licensed or not—are virtually the only persons available to provide maternity care. *E.g.*, Hunter, *supra* note 44, at 70-71; Sutley, *Montana Midwife*, MOTHERING, Summer 1982, at 80; Vogler, *supra* note 10, at 77; see Evenson, *Midwives: Survival of an Ancient Profession*, 7 WOMEN'S RTS. L. REP. 313, 326 (1982).

278. See WASHINGTON DEBATE, *supra* note 92, at 22; JOSIAH MACY, JR. FOUNDATION, THE TRAINING AND RESPONSIBILITIES OF THE MIDWIFE 227 (1966) (remarks of Audrey Wood, General Secretary, Royal College of Midwives, England); Burst, *Our Three-Ring Circus*, J. NURSE-MIDWIFERY, Fall 1978, at 11, 14.

279. See *Midwifery Hearings*, *supra* note 17, at 12 (statement of Sally Tom, American College of Nurse-Midwives); WASHINGTON DEBATE, *supra* note 92, at 39.

280. See *Midwifery Hearings*, *supra* note 17, at 74-75 (testimony of Ruth Watson Lubic,

realized by promoting competition²⁸¹ and by employing lay midwives to provide prenatal care,²⁸² to stay with the mother during labor and delivery,²⁸³ and to be home visitors,²⁸⁴ thereby improving neonatal outcomes.²⁸⁵ Such services are needed particularly for the poor, for whom the level of prenatal care and counseling,²⁸⁶ and consequently neonatal outcome,²⁸⁷ are worst, and exigencies of cost most severe.²⁸⁸

Alternatives in Childbirth—A Statutory Approach

Central to any proposed regulatory scheme is the question of whether minimum qualifications will be prescribed and some form of exclusionary licensing adopted. Many lay midwives support legalization but oppose licensure,²⁸⁹ because they contend that the uniqueness of lay midwifery is incompatible with uniform licensing requirements.²⁹⁰ Alternative proposals call for voluntary certification or registration rather than licensing,²⁹¹ which shift to the consumer the burden of screening

Director, Maternity Care Ass'n); WASHINGTON DEBATE, *supra* note 92, at 39 (non-interventionist techniques).

281. See NATIONAL HEALTH COUNSEL, CREDENTIALING OF HEALTH MANPOWER AND THE PUBLIC INTEREST 23 (1978) (report of Clark Havighurst, Professor of Law, Duke University) [hereinafter cited as NHC REPORT].

282. See *Infant Mortality*, *supra* note 71, at 26; Johnson, *Midwives: Acceptance is Growing Nationwide*, N.Y. Times, June 19, 1979, § 3, at 5, col. 1; see also Theiss, *Clients' Perceptions of Physicians' and Midwives' Prenatal Care*, 80 AM. J. NURSING 684 (1980) (clients rated CNM care higher than physician-provided care).

283. See D. STEWART, *supra* note 24, at 61; Kolle, *The Midwife and the Family Unit*, 17 INT'L J. OBSTETRICS & GYNECOLOGY 121, 122 (1979); Laslie, *supra* note 31, at 190.

284. See Sugarman, *Regionalization of Maternity and Newborn Care: Facts, Fantasies, Flaws, and Fallacies*, in 1 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 83, 94 (D. Stewart & L. Stewart eds. 1979). Midwives used in this capacity are a regular part of maternity care in the Netherlands, D. STEWART, *supra* note 24, at 149, and in West Germany, Kolle, *supra* note 283, at 122.

285. See *Midwifery Hearings*, *supra* note 17, at 12 (prepared statement of Sally Tom, ACNM); Kraus, *Cost-Effectiveness at Whose Cost?*, 29 J. NURSE-MIDWIFERY 1, 2 (1984); Pear, *Report Cites Drop in Prenatal Care*, N.Y. Times, Jan. 4, 1984, § 1, at 17, col. 1; *Pre-Natal Care: Public Funds Can Save Lives and Money*, Detroit Free Press, Mar. 4, 1984, § 2, at 2, col. 1 [hereinafter cited as *Prenatal Care*].

286. See Pear, *supra* note 285; *Prenatal Care*, *supra* note 285.

287. See *Infant Mortality*, *supra* note 71; Cohn, *Group Sees Gap in Black-White Infant Mortality*, Washington Post, Jan. 6, 1984, § 1, at 2, col. 1; *State Exceeds Nation's Black Baby Death Rate*, Detroit News, Jan. 6, 1984, § 1, at 1.

288. See Comment, *supra* note 224, at 173-74; Note, *supra* note 5, at 662-63.

289. See Kreinberg & McSweeney, *An Attitude Survey of Lay-Midwives and Nurse-Midwives*, J. NURSE-MIDWIFERY, May-June 1981, at 43, 48 (96% of lay midwives desired legalization, but only 56% favored licensure).

290. See Hunter, *supra* note 44, at 71; Solares, *The Health Practitioner Registration System: Midwife Independence and Consumer Freedom of Choice*, MOTHERING, Summer 1983, at 69, 70.

291. See M. FRIEDMAN, CAPITALISM AND FREEDOM 149 (1962); Solares, *supra* note 290,

and selecting a qualified birth attendant.

These proposals, however, ignore the practical difficulty parents would have in evaluating midwives under such a system²⁹² and the overriding interest of the state in the welfare of the mother and child. Legalization without regulation would make it extremely difficult to maintain an optimal standard of care.²⁹³ When overly burdensome licensing prerequisites are adopted, however, there is a danger that while a few midwives may seek licensure, most will simply practice outside the system.²⁹⁴ A flexible apprenticeship system that admits those already in practice avoids this problem but still provides minimum assurances of competence.²⁹⁵ The Model Act proposed in this Article adopts this approach²⁹⁶ and also establishes an Advisory Committee on Lay Midwifery, all members of which must have some connection to or experience with midwifery,²⁹⁷ to oversee administration of and recommend

at 69-70 (A midwife would be required to register and to provide state and individual consumers with a description of her education, training, and approach to practice.).

Neither certification nor registration imposes minimum educational or examination requirements to practice legally. Certification would merely provide an indication that an individual met certain criteria necessary for certification. Registration is simply non-exclusionary licensing. Any person may become registered by listing herself with the authority designated by law. Thus, although the Model Act proposed in the appendix to this Article provides for "registration" of lay midwives, it is the equivalent of a licensure system, although it does not prescribe formal educational requirements or a qualifying examination typical of most licensing schemes.

292. See Cavero, *Modern Midwifery: Complicated Rebirth of an Ancient Art*, FAM. & COMMUNITY HEALTH, Nov. 1979, at 32 (absence of standard against which to measure the extent and quality of lay midwife's training); see also NHC REPORT, *supra* note 281, at 16 (report of Dorothy Novello, Dean, Erie Institute for Nursing).

293. See Sullivan & Beeman, *supra* note 97, at 645.

294. See WASHINGTON DEBATE, *supra* note 92, at 46, 70.

295. See Burst, *On the Essentiality of Professional Midwives in Any Good Maternity Plan*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 371, 373 (L. Stewart & D. Stewart eds. 1979).

296. See *infra* Model Act §§ 205-206; cf. Gaskin, *Midwifery: A Birthright of the People*, in D. STEWART, THE FIVE STANDARDS FOR SAFE CHILDBEARING 163, 167-68 (1981) (one woman's experience training farm midwives); Sullivan & Beeman, *supra* note 97, at 641 (describing Arizona scheme); Comment, *supra* note 158, at 114-15 (describing proposed California Act).

The Model Act leaves open the possibility that it may prove desirable to adopt formal educational requirements and a qualifying exam. See *infra* Model Act § 211. The Act seeks to minimize restrictions on entry into the profession if such requirements are adopted by permitting presently registered lay midwives to sit directly for the exam without fulfilling the prescribed requirements, § 211(1), and by providing that such requirements may not be put into effect until a program is established in the state whereby such requirements may be fulfilled, § 211(3).

297. See *infra* Model Act § 209; see also Salmon & Berliner, *supra* note 22, at 540 ("If defining the scope and conditions of practice for new alternative practitioners is left to medical doctors, holistic health care will tend to conform to the constructs of scientific medicine.

modifications to the regulatory scheme.²⁹⁸

Presently, most lay midwives begin practicing with little practical experience and no background in health care.²⁹⁹ Although most lay midwives desire training, at present the opportunities to acquire such training are limited.³⁰⁰ Article II of the Model Act addresses the importance of experience and training. In addition to prescribing basic prerequisites to registration,³⁰¹ the Act makes renewal of registration contingent on continuing education³⁰² and competence.³⁰³

Of equal importance to the well-being of mother and child is a defined scope and standard of practice for lay midwifery and home birth.³⁰⁴ Not all lay midwives are equally conscientious or competent. Many are biased toward home births and may encourage mothers to resist or distrust the diagnoses and recommendations of doctors.³⁰⁵ Whether out of pride or fear of the consequences, lay midwives may be reluctant to acknowledge incipient complications, to call in a back-up physician, or to recommend transport to the hospital.³⁰⁶ In defining a standard of care for lay midwives, the Model Act addresses these problems by prescribing in detail those abnormal conditions that will trigger medical consultation and transfer in the antepartum, intrapartum, and postpartum periods and those tests and observations that must be made to detect such condi-

Given the historical antipathy of organized medicine toward nonconventional therapies, a separate licensing board seems called for . . .").

298. See *infra* Model Act §§ 210(2), 210(3), 211, 216 (option 1), 217 (option 1), 221.

299. See WASHINGTON DEBATE, *supra* note 92, at 36; Burst, *supra* note 295, at 373; Dingley, *supra* note 11, at 240; Kreinberg & McSweeney, *supra* note 289, at 48; Mehl, *Comparisons*, *supra* note 9, at 20, 28.

300. See Cavero, *supra* note 292, at 32; Hurzeler, *supra* note 259, at 59; Raisler, *Interview with a Rural Midwife*, J. NURSE-MIDWIFERY, Winter 1978, at 36; Ventre, *The Lay Midwife*, J. NURSE-MIDWIFERY, Winter 1978, at 33.

301. See *infra* Model Act §§ 204-206.

302. *Id.* §§ 207(1), 210; see Sullivan & Beeman, *supra* note 97, at 644 (continuing education in Arizona).

303. Model Act §§ 207(2), 208(1)(c), (e), (f); see NHC REPORT, *supra* note 281, at 10 (report of Madelaine Gray, Director of Certification, American Occupational Therapy Ass'n, distinguishing continuing competency from continuing education).

304. The combination of an emergency that the midwife has not previously encountered and lack of any standard of practice may result in a tentative, ad hoc reaction with potentially tragic results. See R. KRAMER, *supra* note 58, at 139 ("No amount of experience of normal births is adequate preparation for recognizing or dealing with the dangerously abnormal when it occurs."); Morse, *Home Birth Delivery Dilemma*, Detroit Free Press, Apr. 21, 1983, § B, at 4, col. 4.

305. See Peterson, *Technology as a Last Resort in Home Birth: The Work of Lay Midwives*, 30 SOC. PROBS. 272, 276 (1983); Saldana, *supra* note 86, at 172.

306. See, e.g., Gilmore, *Facing the Worst*, MOTHERING, Summer 1980, at 78; Mills, *The Lay Midwife*, in SAFE ALTERNATIVES IN CHILDBIRTH 129 (D. Stewart & L. Stewart eds. 1976).

tions.³⁰⁷ Within these guidelines, the Act seeks to balance freedom of choice on the part of both parents and midwives with the state's interest in the health of the mother and baby by allowing midwives to perform a wide range of routine and emergency medical procedures when indicated,³⁰⁸ but requiring the lay midwife to obtain prior consent from the mother to agree to emergency transport when recommended by the midwife and her back-up doctor.³⁰⁹ The Act also establishes reporting requirements to enable the Advisory Committee on Lay Midwifery to perform its role of oversight and review.³¹⁰

The system of physician and hospital back-up and apprenticeship training provided in the Model Act depends upon the acceptance of lay midwives by the medical establishment and the willingness of doctors and institutions to assume these secondary roles. There is little indication that this acceptance would occur without assistance.³¹¹ In the past, doctors who have established home birth practices or who have worked in conjunction with midwives have had their licenses threatened or suspended,³¹² their hospital staff privileges revoked,³¹³ and their malpractice insurance cancelled.³¹⁴ Similarly, strong pressure has been exerted to re-

307. See *infra* Model Act §§ 212, 214, 216 (option 2), 217 (option 2).

308. *Id.* §§ 218-219; see Mehl, *supra* note 33, at 130; Sallomi, Pallow & McMahon, *Midwifery and the Law*, MOTHERING, Fall 1981, at 63, 63 (If the midwife is prohibited from using any emergency equipment, performing any medical procedures, or making any independent decisions, she "cannot by any stretch of the imagination practice ethically in the midst of such restrictiveness.").

309. See *infra* Model Act § 220(4). The Act is circumspect regarding unattended home birth. Section 202(1) technically encompasses UHB, because it proscribes provision of care "for compensation or otherwise." See Finch, *supra* note 115 (husband at UHB fined under Midwife Act). Ideally, the positive approach taken and fostered by the Act respecting alternative choices will coax parents away from this unsafe practice. See *supra* note 45. If not, it is probably best to leave punitive action to the general criminal law should a bad outcome result. See *supra* notes 137-46 & accompanying text. See generally Parness, *Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life*, 29 HARV. J. ON LEGIS. 97 (1985).

310. *Id.* § 221; see WASHINGTON DEBATE, *supra* note 92, at 75-76.

311. See WASHINGTON DEBATE, *supra* note 92, at 43 (Officials and medical staff of hospitals have been unwilling to commit resources to providing supervised clinical instruction for midwives, or to permit midwives to attend or even to accompany their clients when hospitalization is required.); Sullivan & Beeman, *supra* note 97, at 645 (licensed lay midwives in Arizona still have difficulty obtaining medical back-up in some areas); Ventre, *supra* note 272, at 114-15.

312. See Krajick, *supra* note 23, at 16.

313. See Annas, *supra* note 15, at 20; Krajick, *supra* note 23, at 17; Mehl, *supra* note 27, at 3, 9; Randal, *The Patient Woman: Are Obstetricians Protecting Her Health or Their Turf?*, THE PROGRESSIVE, Dec. 1980, at 16; Note, *supra* note 5, at 681.

314. See Nurse Midwifery Assocs. v. Hibbett, 549 F. Supp. 1185 (M.D. Tenn. 1982); State Volunteer Mut. Ins. Co., 3 TRADE REG. REP. (CCH) ¶ 22,030 (Sept. 28, 1983); *Midwifery Hearings*, *supra* note 17, at 32 (testimony of William Darrell Martin, M.D.); *id.* at 52 (testi-

strict the practice of nurse midwives, even though they have been legally qualified to practice.³¹⁵

The Model Act explicitly addresses this problem in a number of ways. It requires hospitals to provide neonatal intensive care and high risk obstetrics observation opportunities,³¹⁶ and to permit mothers to have a midwife present during labor and delivery.³¹⁷ It proscribes discrimination in the granting of staff privileges and employment to physicians or others because of their participation in or support of home births or midwife-attended births.³¹⁸ It also proscribes discrimination in the granting of staff privileges and employment to nurse-midwives as primary attendants for low risk women during normal labor and delivery.³¹⁹ It prohibits adverse action by insurance carriers against doctors or nurse midwives who attend or provide back-up care for lay midwives and home births.³²⁰ Finally, it requires that midwives be included in all forms of health care insurance covering services provided by doctors within the scope of practice of midwives.³²¹ The Model Act also addresses the fear of malpractice liability by prescribing that a well-planned home birth within the terms of the Act is *prima facie* evidence that an acceptable standard of care has been followed,³²² as is the informed exercise of choice regarding hospital practices and procedures during labor and delivery³²³ and by eliminating vicarious liability for back-up physicians.³²⁴

The Model Act attempts to provide those who prefer or require the hospital setting for delivery with some degree of choice as well. The Act reinforces informed consent requirements in connection with the use of medication and interventive procedures.³²⁵ It also encourages mothers

mony of Susan Johnson Sizemore, CNM); WASHINGTON DEBATE, *supra* note 92, at 81; Mehl, *supra* note 27, at 9; Hinds, *Midwives Seek Delivery From Discrimination*, N.Y. Times, Aug. 7, 1983, § 4, at 9, col. 1.

315. See *Midwifery Hearings*, *supra* note 17, at 20-21 (testimony of Judy Norsigian, National Women's Health Network) & 32 (testimony of William Darrell Martin, M.D.); Hinds, *supra* note 314; Hunter, *supra* note 44, at 72; Brandstrader, *Special Delivery: As More Women Have Babies in Birth Centers, Doctors, Hospitals Rethink Obstetric Procedures*, Wall St. J., Nov. 29, 1983, at 60, col. 1.

316. *Infra Model Act* § 205.

317. *Id.* § 305(1).

318. *Id.* § 302(1).

319. *Id.* § 305(2). The Act does not, however, require that hospitals grant staff privileges or employment to lay midwives. *Id.* § 305(3).

320. *Id.* § 303(2).

321. *Id.* § 303; cf. ALASKA STAT. § 21.42.355 (Supp. 1983).

322. See *infra Model Act* § 301(1).

323. *Id.* § 301(2).

324. *Id.* § 302(3).

325. *Id.* § 304(3).

to avoid the use of medication throughout pregnancy and labor by requiring the doctors and nurse-midwives to warn the patient of potential harm resulting from the use of such substances.³²⁶

Conclusion

Despite staunch medical opposition, lay midwifery and home birth have rebounded from near extinction to become increasingly credible and popular birth options. Virtually every reported study has shown that, in the aggregate, outcomes of home births in appropriately screened populations attended by experienced, responsible lay midwives with well-coordinated medical back-up are comparable to outcomes in similar populations giving birth in hospital. On an individual level, however, home birth entails certain unique risks with potentially catastrophic consequences for mother and child.

Against this background, both advocates and opponents of home birth and lay midwifery have asserted "rights" arguments as authority for choosing or restricting birth alternatives. Resort to legal compulsion or constitutional prerogative, however, cannot resolve the social-medical conundrum posed by home birth and lay midwifery. Nor are the interests of anyone served when the state casts a blind eye on the problem, effectively forcing a showdown between parents electing such options and a medical establishment determined to discourage them.

The appropriate role of the state should be to mediate between parents and physicians by providing the guidance, encouragement, and oversight necessary to maximize the safety of birth alternatives. A flexible regulatory system for lay midwifery such as that proposed in this Article can accomplish this goal and, in addition, can provide a means for improving care and promoting respect and cooperation between medical providers and consumers.

326. *Id.* § 304(1), (2); cf. N.Y. PUB. HEALTH LAW § 2503 (McKinney Supp. 1983).

Appendix
Legal Status of Lay Midwifery: State by State
Summary

The chart on the following pages summarizes the legal status of the practice of midwifery for each of the states plus the District of Columbia. The information is current as of March 1, 1986.

LAW MIDWIFERY: A STATE BY STATE SUMMARY

| | No Explicit Statutory Treatment | | | Explicit Treatment by Statute | | | | Legal Action Involving Home Birth |
|-------------|---------------------------------|------------------|-----------------|-------------------------------|-------------------------------|-----------------|---|--|
| | permitted | prohibited | undetermined | licensed | not licensed but may practice | prohibited | licenses authorized, but not being issued | limit to licenses issued under repealed statute ¹ |
| Alabama | | | | | | | | X ² |
| Alaska | | | | X ³ | | | | X ⁴ |
| Arizona | | | | X ⁵ | | | | |
| Arkansas | | | | X ⁶ | | | | |
| California | | C ⁷ | | | | | | |
| Colorado | | | | | | X ⁸ | | |
| Connecticut | | | | | | X ⁹ | | |
| Delaware | | | | | | X ¹⁰ | | |
| D.C. | | | | | | | X ¹¹ | |
| Florida | | | | | | | | X ¹² |
| Georgia | | | | | | | X ¹³ | |
| Hawaii | | | | | | X ¹⁴ | | |
| Idaho | | | X ¹⁵ | | | | | |
| Illinois | | | | | | | | X ¹⁶ |
| Indiana | | C ¹⁸ | | | | | | X ¹⁷ |
| Iowa | | AG ¹⁹ | | | | | | |
| Kansas | | AG ²⁰ | | | | | | |

LAY MIDWIFERY: A STATE BY STATE SUMMARY

| | No Explicit Statutory Treatment | | | Explicit Treatment by Statute | | | | Legal Action Involving Home Birth |
|----------------|---------------------------------|------------------|-----------------|-------------------------------|-------------------------------|-----------------|---|--|
| | permitted | prohibited | undetermined | licensed | not licensed but may practice | prohibited | licenses authorized, but not being issued | limit to licenses issued under repealed statute ¹ |
| Kentucky | | | | | | | | X ²¹ |
| Louisiana | | | | | | | | X ²² |
| Maine | | AG ²³ | | | | | | |
| Maryland | | | | | | X ²⁴ | | |
| Massachusetts | C ²⁵ | | | | | | | |
| Michigan | C ²⁶ | | | | | | | X ²⁷ |
| Minnesota | | | | | | | X ²⁸ | |
| Mississippi | | | | | X ²⁹ | | | |
| Missouri | | | | | | | | X ³⁰ |
| Montana | | | | | | X ³¹ | | |
| Nebraska | | | X ³² | | | | | |
| Nevada | C ³³ | | | | | | | |
| New Hampshire | | | | X ³⁴ | | | | |
| New Jersey | | | | X ³⁵ | | | | |
| New Mexico | | | | X ³⁶ | | | | |
| New York | | | | | | X ³⁷ | | X ³⁸ |
| North Carolina | | | | | | | | X ³⁹ |
| North Dakota | | | X ⁴⁰ | | | | | |

LAW MIDWIFERY: A STATE BY STATE SUMMARY

| | No Explicit Statutory Treatment | | | Explicit Treatment by Statute | | | | Legal Action Involving Home Birth |
|----------------|---------------------------------|------------------|-----------------|-------------------------------|-------------------------------|-----------------|---|--|
| | permitted | prohibited | undetermined | licensed | not licensed but may practice | prohibited | licenses authorized, but not being issued | limit to licenses issued under repealed statute ¹ |
| Ohio | | | | | | | | X ⁴¹ |
| Oklahoma | | | X ⁴² | | | | | |
| Oregon | AG ⁴³ | | | | | | | |
| Pennsylvania | | | | | | X ⁴⁴ | | |
| Rhode Island | | | | | | | X ⁴⁵ | |
| South Carolina | | | | X ⁴⁶ | | | | |
| South Dakota | | | X ⁴⁷ | | | | | |
| Tennessee | | | | | X ⁴⁸ | | | |
| Texas | | | | X ⁴⁹ | | | | |
| Utah | | | X ⁵⁰ | | | | | |
| Vermont | | | X ⁵¹ | | | | | |
| Virginia | | | | | | | | X ⁵² |
| Washington | | | | X ⁵³ | | | | |
| West Virginia | | | | | | X ⁵⁴ | | |
| Wisconsin | | AG ⁵⁵ | | | | | | |
| Wyoming | | | X ⁵⁶ | | | | | |
| TOTALS | 4 | 6 | 8 | 9 | 2 | 9 | 4 | 9 |
| | | | | | | | | 4 |

Footnotes for Chart

X the state in the same row as the symbol belongs to the category designated by the column heading.

C the question has been resolved by judicial interpretation.

AG the question has only been addressed in an attorney general's opinion, which is not necessarily conclusive. See generally 7 Am. Jur. 2d *Attorney General* § 11 (1980) (attorney general's opinions may be persuasive but are not binding on courts).

1. Two informative surveys of the legal status of midwifery are Cohn, Cuddihy, Kraus & Tom, *Legislation and Nurse-Midwifery Practice in the USA*, 29 J. NURSE-MIDWIFERY 55 (1984) [hereinafter cited as Cohn], and P. SALLOMI, A. PALLOW-FLEURY & P. MCMAHON, *MIDWIFERY AND THE LAW* (1982) [hereinafter cited as P. SALLOMI], updated by Sallomi, *Midwifery and the Law*, *MOTHERING*, Summer 1983, at 72. Whether a state could be compelled to exercise its statutory authority to administer an examination or issue a license presents a viable legal issue. See Ventre, *The Making of a Legalized Lay Midwife*, 3 BIRTH & FAM. J. 109 (1976) (author compelled State of Maryland in 1975 to issue license under statute that had not been used since 1924). The result of such a challenge in a given case might turn on whether the language of the particular statute in question is interpreted as mandatory or directory. See generally 2A J. SUTHERLAND, *STATUTES AND STATUTORY CONSTRUCTION* § 57 (C. Sands 4th ed. 1973). The relevant language of each statute in question is quoted below.

2. ALA. CODE § 34-19-8 (1985); see also Humphrey, Boyd & Goldenberg, *Out of Hospital Deliveries in Alabama 1940-1980*, J. MED. ALA., Aug. 1982, at 20, 25 (number of licensed granny midwives in state 1942-1980).

3. ALASKA STAT. §§ 18.05.056-.070 (Supp. 1985). The Alaska statute provides for registration rather than licensure. Excepted from the registration requirement are persons who, as of the effective date of the statute, have attended at least ten births and whose cultural traditions have included for at least two generations the practice of lay midwifery. *Id.* § 18.05.057.

4. Dr. Peter Rosi was acquitted of negligent homicide when a newborn died from meconium aspiration after being transferred to a hospital six hours after a home birth that he had attended. See Randal, *The Patient Woman: Are the Obstetricians Protecting her Health or Their Turf?*, *THE PROGRESSIVE*, Dec. 1980, at 16, 17. However, in *Rosi v. State Medical Bd.*, 665 P.2d 28 (Alaska 1983), the court upheld conditions placed on plaintiff's license to practice medicine based on the incident.

5. ARIZ. REV. STAT. ANN. §§ 36-753 to -757 (Supp. 1985). Although Arizona's licensing mechanism has been in place since 1957, because many midwives continued to practice without licenses, the legislature passed a provision in 1982 providing for a one-year period during which unlicensed midwives would be permitted to take the established examination and acquire a provisional license without having completed the requisite training. Act of Apr. 20, 1982, ch. 162, § 4, 1982 Ariz. Sess. Laws 449, codified at ARIZ. REV. STAT. ANN. § 36-751 (Supp. 1985)); see Sullivan & Beeman, *Four Years' Experience with Home Birth by Licensed Midwives in Arizona*, 73 AM. J. PUB. HEALTH 641, 641-42 (1983).

6. ARK. STAT. ANN. §§ 72-604(p), 72-2207 to -2209 (Supp. 1985). In passing the Arkansas Midwifery Act, the legislature declared a state of emergency based on its finding "that adequate maternal care is not readily available in some parts of the state." 1983 Ark. Acts 1981, § 8. Section 72-2208 confines the practice of lay midwifery to counties within the state in which 32.5% or more of the population is living below the poverty level based on the 1980 census. The state Attorney General has expressed the concern that the limiting provision may be unconstitutional either on equal protection grounds or under an amendment to the state constitution prohibiting the passage of Local and Special Acts by the state legislature. See Op. Att'y Gen. No. 83-195 (Oct. 10, 1983).

7. *Bowland v. Municipal Court*, 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630

(1976); see Watchorn, *Midwifery: A History of Statutory Suppression*, 9 GOLDEN GATE L. REV. 631, 636-39 (1978-1979). Despite the *Bowland* decision, estimates of the number of lay midwives active in California range from 500 to 700. See P. SALLOMI, *supra* note 1, at 6 (500 estimated); Collins, *Midwife Indicted for Boy's Death*, NAT'L L.J., July 18, 1983, at 3, 6 (over 700 estimated); Foster, *Up Against the Birth Monopoly*, REASON, Sept. 1982, at 23, 24 (600 estimated). There have been and continue to be numerous prosecutions of midwives. See, e.g., Bowers, *Rosalie Tarpening: The Final Verdict*, MOTHERING, Winter 1982, at 80; Bowers, *Homebirth on Trial, The Rosalie Tarpening Hearing*, MOTHERING, Spring 1981; Hunter, *Mothers & Outlaws*, NEW WEST, Dec. 22, 1980, at 61; Sallomi, *supra* note 1, at 72.

8. COLO. REV. STAT. § 12-36-106(1)(f) (1985). But see COLO. REV. STAT. § 12-36-106(3)(l) (1985) (medical practice act does not prohibit "rendering of services . . . by persons qualified by experience, education, or training, under the personal and responsible direction and supervision of a person licensed under the laws of this state to practice medicine").

9. Section 9 of 83 Conn. Pub. Acts 441 repealed CONN. GEN. STAT. §§ 20-75 to -86 (1983), which had authorized examination and licensing of lay midwives by the State Department of Health. The Department had ceased administering the examination long before the statute was repealed. There had been no applicants for at least six years prior to repeal, and only three midwives were ever licensed under the statute—in 1929, 1935, and 1960. Telephone conversation with representative of State Department of Health (Mar. 24, 1983).

10. DEL. CODE ANN. tit. 16, § 122(3)(h) (Supp. 1984); Delaware State Board of Health, Rules and Regulations Pertaining to the Practice of Midwifery § II(b)(c) (adopted April 17, 1978, amended Sept. 19, 1978, and Dec. 22, 1982).

11. D.C. CODE ANN. §§ 2-1301(2), 2-1307, 2-1314 to -1316, 2-1324(b) (1981); see P. SALLOMI, *supra* note 1, at 8; Cohn, *supra* note 1, at 79. If challenged, the relevant statutory language would be: "The Commission *may* appoint, from time to time, as it deems expedient, a Board of Examiners in Midwifery. . . . The Commission *shall* refer to a Board of Examiners in Midwifery every applicant for a license to practice midwifery . . . for determination of the applicant's fitness so to practice." D.C. CODE ANN. § 2-1314 (1981) (emphasis added).

12. FLA. STAT. ANN. § 467.006 (West Supp. 1985). See generally Comment, *Legitimacy for the Florida Midwife: The Midwifery Practice Act*, 37 U. MIAMI L. REV. 123 (1982).

13. GA. CODE ANN. §§ 88-1401 to -1410 (1985). No new licenses have been issued under this statute since 1963. See P. SALLOMI, *supra* note 1, at 9; Cohn, *supra* note 1, at 83; see also Foreword to GEORGIA DEPARTMENT OF PUBLIC HEALTH, MIDWIFERY LESSON PLANS FOR USE BY PUBLIC HEALTH NURSES (1963) ("The ultimate goal, in the opinion of the Georgia Department of Public Health, is hospitalization for delivery by physicians, rather than delivery by lay midwives."). If challenged, the relevant statutory language would be: "The [Department of Human Resources] or any county board of health designated by the department *shall* issue, or *refuse to issue* . . . certificates of authority to practice midwifery . . ." GA. CODE ANN. § 31-26-2 (1985) (emphasis added).

14. HAWAII REV. STAT. §§ 321-13 to -15 (Supp. 1985); Department of Health, State of Hawaii, Public Health Regulations ch. 6, § 3.2 (1976). There are apparently no lay midwives currently active under the grandfather regulation. See P. SALLOMI, *supra* note 1, at 9. Although revisions of the Public Health Regulations are anticipated and the Hawaii Midwifery Council was invited to submit a proposal in 1982 regarding lay midwives, *id.* at 9-10, the Department presently anticipates that the revision process will produce no major changes in the regulations. Letter from Henry M. Ichiho, Chief, Maternal and Child Health Branch, Family Health Services Division, Hawaii Department of Health (Mar. 2, 1984) (copy on file with *The Hastings Law Journal*).

15. See Attorney General's Selected Guidelines for the Year 1981, at 248. In a "legal guideline" ("not an official Attorney General opinion"), the question of "[w]hether the practice of lay mid-wifery may be in conflict with the Idaho statutes concerning the practice of medicine" was considered. *Id.* The guideline cites *Banti v. State*, 163 Tex. Crim. 89, 289 S.W.2d 244 (1956), which held that midwifery was not within the practice of medicine, and

Bowland v. Municipal Court, 18 Cal. 2d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976), which reached the opposite conclusion. It suggests that, based on the similarity in wording between the California and Idaho statutes defining the practice of medicine, if faced with the question the Idaho courts "might well adopt the reasoning of the California Supreme Court in the *Bowland* case." *Id.* at 250.

16. ILL. REV. STAT. ch. 111, § 4411(3) (Supp. 1985). The Illinois statute was finally upheld against due process and equal protection challenges on February 23, 1982, culminating litigation that began in 1977. See Cohn, *supra* note 1, at 89. The only opinion available from that litigation is *Barasa v. Anderson*, No. 77 C 3383 (N.D. Ill. Mar. 19, 1981) (available on LEXIS, Genfed library, Dist. file) (denying summary judgment); see also *Barasa, Midwifery in Court: Attracting Publicity*, in 2 COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 597 (D. Stewart & L. Stewart eds. 1979).

17. See *Scott v. Association for Childbirth at Home*, 88 Ill. 2d 279, 430 N.E.2d 1012 (1981) (Even assuming that prospective parents do have a constitutionally protected right to learn about or practice home childbirth, investigation pursuant to the Consumer Fraud and Deceptive Practices Act of the advertising and sale by defendants of home birth classes and materials did not chill constitutionally protected speech.).

18. See *Smith v. State*, 459 N.E.2d 401 (Ind. Ct. App. 1984).

19. 1978 Op. Att'y Gen. 371.

20. Op. Att'y Gen. No. 78-164 (May 17, 1978). The opinion also suggests that, should the fetus die, a pregnant woman who "intentionally aids, abets, advises, hires, counsels or procures the husband or midwives to practice midwifery" is liable to a charge of involuntary manslaughter. *Id.* at 5. Thus, this opinion implies that any planned delivery performed without the attendance of a physician is illegal.

21. Statutory authority is delegated to the Human Resources Cabinet to regulate "[t]he practice of midwifery, including the issuance of permits to and supervision of women who practice midwifery." KY. REV. STAT. § 211.180(5) (1982). In 1975, under a regulation more restrictive than the authorizing legislation, the Cabinet ceased issuing licenses to lay midwives. Ky. Admin. Reg. tit. 902, § 4:010 (1985). The attorney general rendered an opinion that the regulation was not inconsistent with the statute. Op. Att'y Gen. No. 82-361 (July 2, 1982). A group of lay midwives filed a suit challenging this regulatory restriction, and the results of a preliminary hearing in January 1983 were favorable to the complainants. See Sallomi, *supra* note 1, at 73. Final disposition of the suit is still pending. In the meantime, following public hearings on lay midwifery, the Cabinet reaffirmed its policy of restricting practice to midwives authorized to practice before the termination of licensure in 1975. Telephone interview with representative of Cabinet for Human Resources (Apr. 23, 1984).

22. LA. REV. STAT. ANN. § 37:1277 (West Supp. 1986).

23. Opinion regarding midwifery, Op. Att'y Gen. (Jan. 27, 1977). The opinion concluded, based on the statutory definitions of medicine and nursing, that lay midwifery practiced for compensation did not constitute the practice of medicine, but did constitute the practice of nursing.

24. MD. HEALTH OCC. CODE ANN. § 7-603 (Supp. 1985).

25. *Leigh v. Board of Registration in Nursing*, 395 Mass. 670, 481 N.E.2d 1347 (1985). The court in *Leigh* distinguished the frequently cited opinion of an earlier court in *Commonwealth v. Porn*, 196 Mass. 326, 82 N.E. 31 (1907), which had upheld the criminal conviction of a midwife for practicing medicine without a license, on the basis that the midwife in *Porn* had been using surgical instruments and prescribing drugs. *Leigh*, 481 N.E.2d at 1353 & n.12. *Leigh* involved a nurse who was not a certified nurse-midwife. The court held that the Massachusetts statute pertaining to nurse-midwifery was intended to govern the practice of midwifery by all nurses, regardless of whether such practice was characterized as "lay midwifery" or "nurse midwifery," but that the statute did not act to prohibit the practice of lay midwifery by non-nurses. *Id.* at 1353. *Contra Leggett v. Tennessee Bd. of Nursing*, 612 S.W.2d 476 (Ct.

App. Tenn. 1980) (nursing regulations only applicable to nurses practicing nurse midwifery, not lay midwifery).

26. *People v. Hildy*, 289 Mich. 536, 286 N.W. 819 (1939). The court quoted with approval 1914 Att'y Gen. Op. 508, which reasoned that statutory provisions imposing duties on physicians, nurses, or midwives regarding reporting of live births and treatment of the newborn's eyes recognized midwifery as a profession distinct from the practice of medicine. Interestingly, the current vital statistics and eye prophylaxis statutes no longer refer separately to midwives. MICH. COMP. LAWS §§ 333.2822 ("physician or other individual in attendance" must report live birth), 333.5254 (prophylaxis must be administered at birth by "health professional in charge") (1982).

27. Lay midwife Dimka Plavljanič was charged in 1983 with involuntary manslaughter following the death of an infant during a home birth that she attended. See *Midwife Charged with Manslaughter in Death of Baby*, Detroit News, Mar. 18, 1983, § B, at 8, col. 4.

28. MINN. STAT. §§ 148.30-.32 (1982). The Board of Medical Examiners policy is that it "would only consider administering an examination should a[n] applicant apply who has the training equivalent to that required of the American College of Midwives." Letter from Arthur W. Poore, Executive Secretary, Minnesota State Board of Medical Examiners (Mar. 2, 1984) (copy on file with *The Hastings Law Journal*). If challenged, the relevant statutory language would be as follows: "This license shall be granted upon the production of a diploma from a school of midwifery recognized by the board or, after examination of the applicant, upon the consent of seven members thereof." MINN. STAT. § 148.31 (1982) (emphasis added).

29. MISS. CODE ANN. §§ 73-25-33, 73-25-35 (1973). These statutes are limited on their face to "females engaged solely in the practice of midwifery." Although the statute permitting midwives to practice without a license remains on the books, the state Board of Health is hostile to their practice and has sought to end it. See P. SALLOMI, *supra* note 1, at 18.

30. MO. REV. STAT. §§ 334.010, 334.260 (1978); see also 29 Op. Att'y Gen. No. 79 (Mar. 9, 1972) (nurse-midwifery constituting practice of medicine, rendered prior to expanded 1975 Nursing Practice Act).

31. MONT. CODE ANN. §§ 37-3-102(1)(a), 37-3-103(j) (1985). In 1982, authorities seized the records and birthing equipment of midwives Joyce Sutley and Leslie Fellers. Responding to strong community support, the District Attorney did not press charges and the items were returned. See P. SALLOMI, *supra* note 1, at 19.

32. The statutory definition of the practice of medicine includes "assum[ing] the duties incident to the practice of . . . obstetrics." NEB. REV. STAT. § 71-1102(1) (1981). However, a statute imposing a duty to report the birth of a crippled child refers to "the physician, midwife, or person acting as midwife, who shall be in attendance upon such a birth." *Id.* § 71-1405.

33. In *Pierce v. Douglas County Dist. Attorney*, No. 12273, slip op. at 3-6 (9th Dist. Ct. Nev. Feb. 19, 1982), the court reasoned that references in various statutes to "the term 'midwife' in the disjunctive (or) when the word physician is used" suggested that the legislature regarded midwifery as a profession distinct from the practice of medicine. The court also suggested, however, that under the broad powers conferred upon it by the legislature, the State Board of Health could "develop reasonable standards and regulations for the supervision and control of midwives pending legislative action to insure that a midwife has the appropriate training and qualification to attend upon women at birth." *Id.* at 8. A contradictory opinion was rendered by the state Attorney General two months later, which contained no reference to the *Pierce* decision. 1982 Op. Att'y Gen. 20. That opinion suggested that the Board of Health lacked the authority to promulgate regulations requiring licensure to practice midwifery. It did conclude that the Board could "adopt reasonable regulations consistent with law concerning the prevention of sickness and disease in newborns, including those delivered by midwives," but cautioned that they could not "impose unduly burdensome restrictions or procedures on midwives . . . tantamount to a licensure scheme." *Id.* at 24.

34. N.H. REV. STAT. ANN. §§ 326-D:1 to -D:6 (1984).

35. N.J. STAT. ANN. §§ 45:10-1 to 10-16 (West 1978); N.J. ADMIN. CODE tit. 13, §§ 35-

9.1(a), .3(c), .4(e), .6(a), (b), (f), (g), (h) (regulations distinguishing the permissible scope of practice of lay and nurse midwives). Although there are four lay midwives currently licensed in New Jersey, as of 1984 no one had been newly licensed since at least 1971. Letter from Charles A. Janousek, Executive Secretary, Division of Consumer Affairs, New Jersey Board of Medical Examiners (Mar. 8, 1984) (copy on file with *The Hastings Law Journal*). Until recently, the Board of Medical Examiners has not been administering the examination for licensure of lay midwives. The Board reports that it is once again administering the examination, although as yet no one has passed it. Telephone conversation with representative of Division of Consumer Affairs, New Jersey Board of Medical Examiners, March 15, 1984.

36. N.M. STAT. ANN. § 24-1-3(R) (Supp. 1981); Health and Environment Department, Health Services Division, Regulations Governing the Practice of Lay Midwifery (HED-82-1 (HSD) (1982).

37. N.Y. PUB. HEALTH LAW § 2560 (McKinney 1985).

38. In 1981, the New York State Board for Professional Medical Conduct charged Dr. George Wootan with professional misconduct, based on incidents associated with his home birth practice. This charge resulted in suspension for 60 days of Dr. Wootan's license to practice under a statute permitting summary action when the physician's conduct constitutes an "imminent danger to health." In *Wootan v. Axelrod*, 87 A.D.2d 913, 449 N.Y.S.2d 351 (1982), the court held that the commissioner exceeded his authority by completely suspending Dr. Wootan's license to practice when the order could have been confined to the separable obstetric portion of his practice. The commissioner then added a charge relating to Dr. Wootan's general practice, and in *Wootan v. Axelrod*, 91 A.D.2d 766, 458 N.Y.S.2d 273 (1982), the court held that the additional charge "raised serious questions concerning petitioner's overall competence" and sustained the commissioner's order of a general suspension. See generally Krajick, *Home vs. Hospital—Where Are Baby, Mother (and Doctor) Safer?*, THE NEW PHYSICIAN, No. 7, 1982, at 14; Wootan, *The Dr. George Wootan Story: A Family Under Siege*, MOTHERING, Spring 1982, at 75; Whitehouse, *Battle Is Joined Over "Home Birthing"*, N.Y. Times, Dec. 2, 1981, § 1, at 1, col. 3. Doctor Wootan's license was formally revoked October 21, 1983. See Williams, *State Regents Cancel License of Doctor in Home-Birthings*, N.Y. Times, Oct. 22, 1983, § 1, at 26, col. 1.

39. Midwifery Practice Act, N.C. GEN. STAT. § 90-178.1 (1985); see Valauri, *Anatomy of a Bill*, 44 N.C. MED. J. 554 (1983). In An Act to Study and Regulate the Practice of Midwifery in North Carolina, 1981 N.C. Sess. Laws ch. 676, § 1, at 974, the legislature directed the Secretary of the Department of Human Resources "to undertake a study of the safety and efficacy of out-of-hospital delivery." The results of that study are reported in N.C. DEPT. OF HUMAN RESOURCES, REPORT ON MIDWIFERY (1983).

40. The statutory provision on prevention of infant blindness refers to physicians and midwives. N.D. CENT. CODE § 23-07-10 (1978).

41. OHIO REV. CODE ANN. § 4731.30 (Page Supp. 1984).

42. OKLA. STAT. tit. 59, § 577.6 (1981) ("This [nurse-midwifery act] shall not apply to: . . . (5) the practice of midwifery in connection with spiritual convictions and practices of any established church or religious denomination. No person practicing lay midwifery shall hold herself out as a certified nurse midwife.").

43. 38 Op. Att'y Gen. 967 (1977). The opinion suggests, however, that episiotomy and administration of medication are within the statutory definitions of the practice of medicine or nursing and may not be performed by lay midwives. *Id.* at 972-74; see also OR. REV. STAT. §§ 432.205 (birth registration), 418.300 (child placement) (1985), the former of which refers to "the physician or any other person in attendance" at a birth, and the latter to physicians, nurses, midwives, and various others.

44. PA. STAT. ANN. tit. 63, §§ 171-176 (Purdon 1968); 49 PA. ADMIN. CODE §§ 17.71-.78 (Shepard's 1979). Only licensed registered nurses will be admitted to the midwife examination. *Id.* § 17.73(a).

45. R.I. GEN. LAWS § 23-13-9 (1985); Dept. of Health, Rules and Regulations for Li-

censing of Midwives (R23-13-MID) (1982). The Regulations contemplate licensure of lay as well as nurse-midwives. *See, e.g.*, Reg. 902.1 (The Advisory Council on Midwifery included "two (2) midwives, one of whom shall be a nurse-midwife."). Presently, there are no educational programs for lay midwives that meet the stringent requirements of the regulations. Reg. 905.2; *see* P. SALLOMI, *supra* note 1, at 23. As of February 1984, no program had been approved under the regulations, nor was creation of any such program planned, and no midwife licensed in another state had been granted a license to practice in Rhode Island per Reg. 906.2. Letter from Robert W. McClanaghan, Administrator, Division of Professional Regulation, Department of Health (Feb. 27, 1984) (copy on file with *The Hastings Law Journal*). If challenged, the relevant statutory language would be as follows: "The state director of health is hereby *authorized and directed* to make rules for the regulation of the practice of midwifery and for the licensing of midwives." R.I. GEN. LAWS § 23-13-9 (1985) (emphasis added).

46. S.C. CODE ANN. § 61-24 (Law. Co-op. 1983).

47. The medical practice act defines obstetrics as the practice of medicine. S.D. CODIFIED LAWS ANN. § 36-4-8 (1977). But the infant eye treatment provision refers to "the physician, surgeon, obstetrician, nurse, or midwife in attendance." *Id.* § 34-24-8 (Supp. 1984).

48. Midwifery is explicitly excluded from the statutory definition of the practice of medicine. TENN. CODE ANN. § 63-6-204(a) (Supp. 1983); *see also* Leggett v. Tennessee Bd. of Nursing, 612 S.W.2d 476 (Tenn. Ct. App. 1980) (midwifery is not practice of nursing).

49. TEX. STAT. ANN. art. 4512i, §§ 1-20 (Vernon Supp. 1986). Prior to passage of the statute in 1983, lay midwives practiced legally without licensure, on the authority of *Banti v. State*, 163 Tex. Crim. 89, 289 S.W.2d 244 (1956). In *Banti*, the court held that midwifery was not included within the practice of medicine, citing reporting and eye prophylaxis statutes referring to physicians and midwives. Op. Att'y Gen. No. H-1293 (Dec. 19, 1978) permitted midwives to perform episiotomies and suture as well as to administer medication under direction of a physician. Section 17(c) of the statute prohibits the use of surgical instruments, except to cut the umbilical cord.

50. UTAH CODE ANN. § 58-44-11 (Supp. 1983) ("This [nurse-midwifery statute] shall in no way or at any time abridge, limit or change in any way the right of a mother and/or father to deliver their baby where, when, how and with whom they choose regardless of certification.").

51. The Vermont birth reporting provision refers to physicians and midwives. VT. STAT. ANN. tit. 18, § 5071(a) (Supp. 1985). It was suggested in 1971 Op. Att'y Gen. 350, 351, with regard to nurse-midwifery, that midwifery constitutes the practice of obstetrics and hence is within the scope of the practice of medicine. While nurse-midwifery is no longer at issue, the logic of the attorney general's opinion would apply equally to lay midwifery. In 1981, Carol Gison-Warnock, a lay midwife, was acquitted of charges of practicing medicine without a license. *See Midwifery is Disputed*, N.Y. Times, July 12, 1981, § 1, at 40, col. 1.

52. VA. CODE § 32.1-147 (1985).

53. WASH. REV. CODE § 18.50 (1983); WASH. ADMIN. CODE §§ 308-115-050 to -405 (1983).

54. W. VA. CODE § 30-15-2 (1980) extinguishes grandfather rights of prior licensees; § 30-15-3 (1980) limits licensure to registered nurse-midwives who have graduated from a school approved by the American College of Nurse-Midwives ("ACNM") and received ACNM certification.

55. WIS. STAT. § 448.10(5) (1982) provides grandfather rights for lay midwives licensed prior to 1953. Shortly after adoption of the statute, an attorney general opinion was rendered suggesting that midwifery practiced by an unlicensed person constituted the practice of medicine. 44 Op. Att'y Gen. 94 (1955). The opinion rejected the argument that the two were considered distinct by the legislature because both physicians and midwives are mentioned in the birth reporting and eye prophylaxis statutes, reasoning that "midwives" referred to *licensed* midwives only. *Id.* at 96-97.

56. WYO. STAT. § 33-26-126 (1977) (repealed by 1979 Wyo. Sess. Laws ch. 5, § 1) per-

mitted the Board of Medical Examiners to examine and issue licenses to practice midwifery to those without authority to practice medicine, and prohibited practice by those not so licensed. It is not clear whether this authority was ever exercised, nor whether repeal of the provision strengthens or weakens the legal status of lay midwives.

Model Act

An Act to provide for the registration of lay midwives; to establish minimum qualifications and a scope of practice for lay midwifery; and to broaden and secure parents' and practitioners' freedom of choice in the manner, cost, and setting of their children's births.

The People of the State of _____ enact

Article I—General Provisions

Sec. 101. This Act shall be known as the "Comprehensive Childbirth Act."

Sec. 102. The Legislature recognizes the need for parents' freedom of choice in the manner, cost, and setting of their children's births. The Legislature finds that the interests of public health require regulation of the provision of childbirth services for the purpose of protecting the health and welfare of mothers and infants, and for the purpose of making the practice of nonphysician childbirth attendants safe and available.

Sec. 103. As used in this Act,

- (1) "certified nurse-midwife" means a registered nurse who has been certified by the American College of Nurse-Midwives; and is licensed to practice in this state;
- (2) "Department of Public Health" means the State Department of Public Health;
- (3) "lay midwife" means a person not a licensed physician or certified nurse midwife registered to practice in this state in accordance with the provisions of Article II of this Act;
- (4) "local health department" means the county, city, or district health department of a particular locale, established in accordance with the state Public Health Code.

Article II—Lay Midwives

Sec. 201. The lay midwife may provide care to low risk patients determined by evaluation and examination to be prospectively normal for pregnancy and childbirth. Such care includes:

- (1) prenatal supervision and counseling;
- (2) preparation for childbirth;
- (3) supervision and care during labor and delivery and care of the mother and the newborn in the immediate postpartum period, so long as progress meets criteria generally accepted as normal.

Sec. 202. (1) No person shall provide any services which constitute lay midwifery, for compensation or otherwise, unless currently registered as a lay midwife in accordance with this Act, or under the direct supervision of a physician, certified nurse-midwife, or registered lay midwife per sec. 206.

(2) This Act shall not be construed to include emergency services provided by lay persons or emergency care providers under emergency conditions.

Sec. 203. Lay midwives shall register with the local health departments of their residence. Local health departments may charge reasonable fees and establish rules and regulations supplementary to the registration procedure. They may not, however, deny or hinder the registration of applicants fulfilling the substantive qualifications specified in this Act.

Sec. 204. Applicants for registration as lay midwives must submit:

- (1) evidence of completion of high school or its equivalent;
- (2) evidence of completion of clinical experience as required per sec. 205;
- (3) evidence of current certification in cardio-pulmonary resuscitation of the adult and newborn;
- (4) four recommendations, one from a physician or certified nurse-midwife and one from a member of the community who have known the applicant for at least one year, and two from women to whom the applicant has provided care;
- (5) a written plan for consultation with a back-up physician licensed under the laws of this state, emergency transfer, transport of an infant to a newborn nursery or neonatal intensive

care nursery, and transport of a woman to an appropriate obstetrical department or patient care area. The plan must be signed and notarized by the applicant's back-up physician.

Sec. 205. Clinical experience in lay midwifery may be obtained in any setting (e.g., office, clinic, hospital, maternity center, home). Clinical experience must include at least the following types and numbers of experiences:

- (1) prenatal visits: 100;
- (2) labor observations and managements, including delivery of newborn and placenta: 50;
- (3) newborn examinations: 30;
- (4) postpartum visits to mother and baby within 36 hours: 30;
- (5) neonatal intensive care nursery observation: 40 hours;
- (6) high risk obstetric care observation: 40 hours;
- (7) observation of cesarean section deliveries: 5;
- (8) observation of forceps or vacuum deliveries: 5;
- (9) observation of one complete series of prepared childbirth classes consisting of at least six meetings;
- (10) observation of one complete breast-feeding series of at least four meetings.

Hospitals providing neonatal intensive care nurseries or high-risk obstetric care shall provide observation opportunities to prospective lay midwives seeking to fulfill the above requirements provided the prospective lay midwife presents a letter from the licensed physician or certified nurse-midwife directly supervising the individual making the request, or supervising the registered lay midwife under whom the individual is obtaining clinical experience.

Sec. 206. (1) Prospective registrants must obtain their clinical experience per sec. 205 (1)-(6) under the direct supervision of a physician, certified nurse-midwife, or registered lay midwife. Direct supervision means that the supervisor is present during the clinical experience and is in the same room.

(2) For a period of one year from the effective date of this Act, the direct supervision requirement is waived. Registration shall be permitted upon presentation of a notarized affidavit by the applicant providing names and dates in fulfillment of clinical experience requirements per sec. 205 (1)-(4) in addition to satisfaction of other requirements under this Article. Registration pursuant to this subsection is renewable only upon written documentation of successful delivery of fifteen women in childbirth during the two year registration period.

(3) Proof of clinical experience will be deemed satisfied upon demonstration that the applicant

- (a) holds a valid certificate or diploma from a foreign institution of midwifery, or
- (b) holds a valid certificate or license to practice midwifery from another state, provided that the requirements therefor are deemed by the Department of Public Health in consultation with the Advisory Committee on Lay Midwifery to be substantially equivalent to those established under this Act.

Sec. 207. The registration of every lay midwife must be renewed every two years. An applicant for renewal shall submit:

- (1) evidence of completion of sixty hours of approved continuing education per sec. 210;
- (2) letters(s) of satisfactory performance from the applicant's back-up physician(s) during the registration period.

Sec. 208. (1) Registration may be revoked or renewal denied or the registrant may be placed on probation pursuant to reasonable remedial conditions by local health departments for any of the following reasons:

- (a) attempting to procure or procuring or renewing registration as a lay midwife by bribery, fraudulent misrepresentation, or through an error of the local health department;
- (b) commission of any crime involving moral turpitude relevant to the practice of midwifery;
- (c) being unable to practice midwifery with reasonable skill and safety to patients by reason of illness, drunkenness, or use of drugs, narcotics, chemicals or other substances, or as a result of any physical or mental condition;

- (d) failure to file or filing false quarterly reports as required per sec. 221;
 - (e) engaging in unprofessional conduct, including, but not limited to, failure to comply with the standards and scope of practice for lay midwifery as established by this Act, in which case actual injury need not be established;
 - (f) letter(s) of unsatisfactory performance from back-up physician(s).
- (2) When action is taken under this section, the registrant shall be furnished with notice of the violation alleged and be given a hearing before a hearing examiner, with right of appeal to the Director of the Department of Public Health.

Sec. 209. The Department of Public Health shall establish an Advisory Committee on Lay Midwifery.

(1) The committee shall consist of five members, appointed by the Director of the Department of Public Health for terms of two years. Members of the committee shall serve without compensation and include:

- (a) one physician who is an obstetrician board certified or eligible for certification by the American College of Obstetrics and Gynecology or a family physician currently practicing obstetrics who is familiar with high risk pregnancies, and has experience working with midwives;
- (b) one certified nurse-midwife;
- (c) two registered lay midwives;
- (d) one member of the general public who has been attended by a midwife during at least one delivery, has never offered her services to others as a midwife, and has no financial interest in the practice of midwifery or in any facility, agency, or insurer of health care.

(2) The committee shall meet at least every six months, and shall report annually to the Director of the Department of Public Health concerning the practice of lay midwifery in this state. The report shall include any recommendations of the committee to increase the quality and safety of lay midwife services and generally to ensure competence in practice.

Sec. 210. (1) Continuing education may be obtained through organized courses, conferences, area midwives meetings, or other mechanisms.

(2) The Director of the state Bureau of Maternal and Child Health, in consultation with the Advisory Committee on Lay Midwifery, shall

- (a) review existing continuing education opportunities and develop additional ones, and
- (b) determine the acceptability of continuing education submitted by an applicant for registration renewal and challenged by the local health department with whom the applicant is registered.

(3) In any calendar year, the Director of the state Bureau of Maternal and Child Health, in consultation with the Advisory Committee on Lay Midwifery, may require specific topics for continuing education based upon any problem areas indicated by lay midwives' quarterly reports.

Sec. 211. Should it be deemed in the best interests of public health and safety, the Department of Public Health, in consultation with the Advisory Committee on Lay Midwifery, may develop formal educational requirements and require an examination as prerequisites to the practice of lay midwifery.

(1) Should such requirements be established, lay midwives currently registered, or who become registered within one year of the establishment of the requirements, shall be permitted to sit directly for such an examination without fulfilling the formal educational prerequisites.

(2) Formal educational requirements shall not be put into effect until a program is established in this state whereby such requirements may be fulfilled.

(3) Should an examination requirement be put into effect, lay midwives shall be permitted to continue in practice until such time as the Department of Public Health administers and grades the examination.

(4) Should formal educational requirements be put into effect, the Department of Public Health, in consultation with the Advisory Committee on Lay Midwifery, shall review and

approve programs in other states or foreign countries, completion of which will permit applicants to sit directly for the examination in this state.

Sec. 212. (1) The lay midwife must require that the patient have a physical examination by the midwife's back-up physician and be found to be essentially normal or low risk before the lay midwife assumes her care.

(2) Initial physician examination shall include clinical pelvimetry and the following laboratory tests: VDRL, GC screen, blood group and Rh, hematocrit or hemoglobin with red cell indices, rubella titer, and urinalysis. Hematocrit or hemoglobin must be rechecked at 28 and 36 weeks gestation.

Sec. 213. (1) Prenatal visits should be every four weeks until 28 weeks gestation, every two weeks from 28 until 35 weeks gestation, and weekly from 36 weeks until delivery.

(2) Each woman must have one prenatal visit with the midwife's back-up physician at 36-40 weeks.

(3) For home births, the lay midwife will make a home visit three to five weeks prior to the estimated date of delivery to assess the physical environment, to ascertain whether the woman has all necessary supplies, to prepare the family for birth, and to instruct the family to correct problems or deficiencies.

Sec. 214. (1) The lay midwife must remain with the mother for at least two hours postpartum, or until the mother's condition is stable and the infant's condition is stable, whichever is longer. Maternal stability is evidenced by normal blood pressure, pulse respirations, fundus firm, and lochia normal. Infant stability is evidenced by established respirations, normal temperature, good color, lack of cyanosis, and strong sucking.

(2) The lay midwife must accompany to the hospital any mother or infant requiring hospitalization, and must give pertinent written records and a verbal report to the physician assuming care. If possible, the lay midwife should remain with the mother and/or infant to provide support and ascertain outcome.

(3) The lay midwife must recommend that any infant delivered by the midwife be evaluated by a physician within three days of age, or sooner if it becomes apparent that the newborn needs medical attention.

(4) The lay midwife shall make postpartum visits to evaluate the condition of mother and infant at least twice—once within 36 hours of birth and once on the fourth or fifth postpartum day. Additional visits shall be made as indicated.

(5) In case of an unsensitized Rh negative mother, the lay midwife shall

(a) obtain a sample of cord blood from the placenta and arrange for testing within 24 hours of the birth;

(b) obtain a repeat antibody screen at 28 weeks and, if negative, offer antenatal Rh immunoglobulin;

(c) be certain that the mother receives Rh immunoglobulin as indicated within 72 hours of delivery.

(6) In case of a mother with no evidence of rubella immunity, the midwife shall recommend administration of rubella vaccine postpartum.

Sec. 215. (1) The lay midwife shall maintain all equipment used in the practice of midwifery in an aseptically clean manner and in working order.

(2) The lay midwife shall maintain records on each patient. Inactive records shall be maintained no less than ten years. All records are subject to review by the local and state departments of health.

(3) The lay midwife shall comply with all laws and regulations applicable to other birth attendants, including prevention of infant blindness and filing of vital statistics.

Sec. 216 (Option 1). (1) In accordance with the requirement that lay midwives provide care only to low risk women, the Director of the Department of Public Health, in conjunction with the Advisory Committee on Lay Midwifery,

(a) shall implement regulations defining those conditions and circumstances that exclude a woman from the classification of low risk;

(b) periodically review the regulations and make them more or less stringent as warranted by the information provided by lay midwives' quarterly reports.

Sec. 216 (Option 2). In accordance with the requirement that lay midwives provide care only to low risk women, lay midwives shall not knowingly assume or continue to care for a woman who

- (1) has had a previous cesarean section or other known uterine surgery;
- (2) has a history of difficult to control hemorrhage with previous deliveries;
- (3) has a history of thrombophlebitis or pulmonary embolism;
- (4) has diabetes, hypertension, Rh disease with positive titer, active tuberculosis, active syphilis, active gonorrhea, epilepsy, hepatitis, heart disease, lung disease, or kidney disease;
- (5) contracts genital herpes simplex in the first trimester or has active genital herpes in the last four weeks of pregnancy;
- (6) has severe psychiatric illness or a history of severe psychiatric illness in the six month period prior to pregnancy;
- (7) is addicted to narcotics or other drugs;
- (8) ingests more than 2 ounces of alcohol or 24 ounces of beer a day on a regular basis or participates in binge drinking, and is unlikely to cease during pregnancy;
- (9) smokes 20 cigarettes or more per day, and is unlikely to cease during pregnancy;
- (10) has multiple gestation;
- (11) has a fetus less than 37 weeks gestation at the onset of labor;
- (12) has a gestation at 42 weeks by dates and examination;
- (13) has a fetus in any presentation other than vertex at the onset of labor;
- (14) is a primigravida with an unengaged fetal head in active labor, or any woman who has rupture of the membranes with unengaged fetal head, with or without labor;
- (15) has a fetus with suspected or diagnosed congenital anomalies that may require immediate medical intervention;
- (16) has preeclampsia;
- (17) has a parity greater than 5;
- (18) has any other abnormal condition reasonably warranting medical care.

Sec. 217 (Option 1). The Director of the Department of Public Health, in consultation with the Advisory Committee on Lay Midwifery, shall implement and periodically review regulations describing those conditions and circumstances of the mother and infant arising during the antepartum, intrapartum and postpartum periods for which the lay midwife shall obtain medical consultation or care.

Sec. 217 (Option 2). The lay midwife shall obtain medical consultation or refer for medical care any woman in her care who

- (1) during the antepartum period
 - (a) develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure;
 - (b) develops edema of the face and hands;
 - (c) develops severe, persistent headaches, epigastric pain or visual disturbances;
 - (d) does not gain 14 pounds by 30 weeks gestation or at least 4 pounds a month in the last trimester or gains more than 6 pounds in 2 weeks in any trimester;
 - (e) develops glucosuria or proteinuria;
 - (f) has symptoms of vaginitis;
 - (g) has symptoms of urinary tract infection;
 - (h) has vaginal bleeding before the onset of labor;
 - (i) has rupture of membranes prior to 37 weeks gestation;
 - (j) has marked decrease in or cessation of fetal movement;
 - (k) has inappropriate gestational size;
 - (l) has demonstrated anemia by blood test (hematocrit less than 30%);
 - (m) has a fever of 100.4 degrees F. or 38 degrees C. for 24 hours;
 - (n) has effacement and/or dilation of the cervix prior to 36 weeks gestation;
 - (o) has polyhydramnios or olighydramnios;

- (p) has excessive vomiting at any gestational stage or continued vomiting after 24 weeks gestation;
- (q) is found to be Rh negative;
- (r) has severe, protruding varicose veins of extremities or vulva;
- (s) develops genital lesions of herpes simplex;
- (2) during the intrapartum period
 - (a) develops a blood pressure of 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic over her normal blood pressure;
 - (b) develops severe headache, epigastric pain, visual disturbance, or convulsions;
 - (c) develops proteinuria or oliguria;
 - (d) develops a fever over 100.4 degrees F. or 38 degrees C.;
 - (e) develops respiratory distress;
 - (f) has persistent or recurrent fetal heart tones below 100 or above 160 beats per minute between or during contractions, or a fetal heart rate that is irregular;
 - (g) develops a pattern of uterine hyperstimulation;
 - (h) has ruptured membranes without the onset of labor for 12 hours;
 - (i) has bleeding prior to delivery;
 - (j) has meconium-stained amniotic fluid;
 - (k) has a presenting part other than vertex;
 - (l) does not progress in effacement, dilation, or station after 2 hours of active labor;
 - (m) has not entered second stage of labor within 24 hours of rupture or the onset of labor, whichever occurred earlier;
 - (n) does not deliver the placenta within 1 hour if there is no bleeding and the fundus is firm;
 - (o) has a partially separated placenta with bleeding or with a blood pressure below 100 systolic or with a pulse rate over 100 beats per minute or who is weak and dizzy;
 - (p) bleeds more than 1000 cc (4 cups) with or after the delivery of the placenta;
 - (q) has retained placental fragments or membranes;
 - (r) desires medical consultation or transfer;
- (3) during the postpartum period
 - (a) develops a blood pressure of 140/90;
 - (b) has a third or fourth degree laceration, deep vaginal laceration, or cervical laceration;
 - (c) has uterine atony;
 - (d) bleeds in an amount greater than normal lochial flow;
 - (e) does not void within 6 hours of birth;
 - (f) develops a fever of 100.4 degrees F. or 38 degrees C. on any 2 of the first 10 days postpartum excluding the first 24 hours;
 - (g) develops foul-smelling lochia;
 - (h) develops evidence of infection of laceration repair;
- (4) or at any time presents any other abnormal condition reasonably warranting medical consultation or care.
- (5) The lay midwife shall obtain medical consultation or refer for medical care any infant who:
 - (a) has an Apgar score of 7 or less at 5 minutes;
 - (b) has any obvious anomaly;
 - (c) develops grunting respirations, retractions, or cyanosis;
 - (d) has cardiac irregularities;
 - (e) has a pale, cyanotic, or grey color;
 - (f) develops jaundice within 48 hours of birth;
 - (g) has an abnormal cry;
 - (h) weighs less than 5½ pounds or 2500 grams or weighs more than 9 pounds or 4100 grams;
 - (i) shows signs of prematurity, dysmaturity, or postmaturity;
 - (j) has meconium staining;

- (j) does not urinate or pass meconium in the first 12 hours after birth;
- (k) is lethargic or does not feed well;
- (l) has edema;
- (m) appears weak or flaccid, has abnormal feces, or appears not to be normal in any other respect.

Sec. 218. (1) The lay midwife will not perform routinely any operative procedures other than:

- (a) artificial rupture of the membranes at the introitus;
 - (b) clamping and cutting the umbilical cord;
 - (c) repairing first or second degree perineal lacerations or episiotomy if done.
- (2) The lay midwife will not administer any restricted drugs or medications except when specifically ordered to do so by a physician or when administering medication in accordance with the law governing prevention of infant blindness.
- (3) The lay midwife will not use any artificial, forcible, or mechanical means to assist the birth.
- (4) The lay midwife will not attempt to correct fetal presentations by external or internal version.

Sec. 219. The following measures are permissible in an emergency situation:

- (1) cardio-pulmonary resuscitation;
- (2) episiotomy;
- (3) intramuscular administration of pitocin for the control of postpartum hemorrhage in accordance with a prescription or a standing order from the midwife's back-up physician.

When any measures listed in this section are utilized, the midwife's back-up physician must be notified in detail of the emergency situation, the measure taken, and the outcome.

Sec. 220. (1) The lay midwife must inform any woman seeking the midwife's services of the midwife's qualifications.

(2) The lay midwife must inform any woman desiring home birth of the possible risks of home birth.

- (3) The lay midwife must inform any woman seeking the midwife's services
- (a) of the requirements imposed upon the lay midwife's practice per secs. 212 and 213;
 - (b) of the limitations on the lay midwife's scope of practice per secs. 216 and 218;
 - (c) of the lay midwife's written plan for medical consultation and emergency transport;
 - (d) of the circumstances under which the lay midwife must consult with a physician per sec. 217.

(4) The lay midwife must obtain the written consent of any woman seeking her services to comply with the judgment of the physician and midwife after consultation as directed by sec. 217 and permit a physician to assume her care or transport to a hospital in the case of a home birth, should such a course of action be deemed necessary to safeguard the life of mother or child.

Sec. 221. (1) The lay midwife shall submit quarterly to the state Bureau of Maternal and Child Health a summary report in a form prescribed by the bureau.

(2) The bureau will make available to local health departments an ample supply of quarterly report forms for use by lay midwives.

(3) The bureau will compile the information contained in the quarterly reports and make these compilations available to the Advisory Committee on Lay Midwifery, lay midwives, and other interested persons and groups.

Sec. 222. (1) Any person hereafter practicing lay midwifery in this state without complying with the provisions of this Act shall be guilty of a misdemeanor.

(2) The Department of Public Health, local health department, or any state attorney may, in addition to or in lieu of other remedies provided in this Act, bring an action for an injunction to restrain violations of this Act.

Article III—Rights, Responsibilities and Standards of Care in Childbirth

Sec. 301. (1) Attendance by a physician, certified nurse-midwife, or registered lay midwife at a home birth in accordance with the provisions of this Act is prima facie evidence that acceptable standards of care have been followed.

(2) Informed exercise of patient choice regarding hospital practices and procedures during labor and delivery is prima facie evidence that acceptable standards of care have been followed.

Sec. 302. (1) A hospital, clinic, institution, teaching institution, or other health facility shall not discriminate against or deny staff privileges or employment to a physician or any other person because that individual has participated in, or expressed a willingness to participate in, a home birth or midwife-attended birth.

(2) Providers of malpractice insurance shall not deny, suspend, or unjustifiably increase the cost of coverage to physicians or certified nurse-midwives attending or providing back-up care for lay midwives or home births.

(3) Back-up physicians shall not be vicariously liable for the negligence of registered lay midwives or certified nurse-midwives.

Sec. 303. (1) Any form of health care reimbursement that provides payment for the cost of services of a physician provided to women during pregnancy, childbirth, and the period after childbirth shall also provide payment in a reasonable amount for a certified nurse-midwife or registered lay midwife who provides the same services, if the services provided are within their authorized scope of practice.

(2) Any health care plan that provides for furnishing those services required of a physician in the care of a woman during pregnancy, childbirth, and the period after childbirth shall also provide that a certified nurse-midwife or registered lay midwife may furnish those same services that are within their authorized scope of practice.

(3) This section shall extend broadly to all forms of health care coverage or reimbursement, including but not limited to fraternal and commercial health insurance organizations, service benefit plans, preferred provider organizations, diagnostic related groups, usual and customary reimbursement, health maintenance organizations, and voucher systems.

Sec. 304. (1) The physician or certified nurse-midwife to be in attendance at the birth of a child shall inform the expectant mother, in advance of the birth, of the drugs and interventional procedures that such physician or certified nurse-midwife expects may be employed at birth, and of the possible effects of such drugs and interventional procedures on mother and child.

(2) The physician or certified nurse-midwife shall obtain a signed consent form for the use of such drugs and interventional procedures.

(3) Even if written consent has been obtained prior to the onset of labor for the administration of an obstetric drug or performance of an interventional procedure, before such drug is administered or interventional procedure performed the woman must be informed of the action about to be taken and the reasons therefor, and given the opportunity to decline the suggested treatment, unless a bona fide medical emergency prevents obtaining such contemporaneous oral consent.

Sec. 305. (1) Unless prevented by a bona fide medical emergency, a woman has the right during a hospital birth, including after transport of a planned out-of-hospital birth, to have the father of her child and a registered lay midwife or certified nurse-midwife with her during labor and delivery.

(2) Hospitals may not discriminate against qualified nurse-midwives in the granting of staff privileges or employment to attend and deliver low risk women during normal labor with physician back-up.

(3) Hospitals may grant or deny staff privileges or employment to registered lay midwives to provide prenatal care or attend and deliver low risk women during normal labor with physician back-up.

Sec. 306. The Department of Public Health shall develop an informational booklet describing the options available to women for childbirth attendants and settings, including physicians,

certified nurse-midwives, registered lay midwives, hospitals, birthing rooms, free standing birth centers, and home births. All childbirth attendants and facilities offering their services in this state shall maintain a supply of such booklets and provide one free of charge to each woman seeking their services.