

Baby Steps: The Changing Relationship Between Michigan Obstetricians and Certified Professional Midwives

Deborah M. Fisch

Follow this and additional works at: <http://scholarship.law.marquette.edu/elders>

 Part of the [Law Commons](#)

Recommended Citation

14 MARQ. ELDER'S ADVISOR 87 (2012)

This Article is brought to you for free and open access by the Journals at Marquette Law Scholarly Commons. It has been accepted for inclusion in Marquette Elder's Advisor by an authorized administrator of Marquette Law Scholarly Commons. For more information, please contact megan.obrien@marquette.edu.

BABY STEPS: THE CHANGING RELATIONSHIP BETWEEN MICHIGAN OBSTENTRICIANS AND CERTIFIED PROFESSTIONAL MIDWIVES

Deborah Fisch*

INTRODUCTION

Exclusion, Coexistence, Subordination, and Cooperation constitute four possible relationships between obstetricians (OBs) and Certified Professional Midwives (CPMs).¹ Michigan

* A.B., Linguistics, University of Michigan, 1988; J.D., Wayne State University, 2011. The author is deeply grateful for mentoring and inspiration received from Edward B. Goldman, J.D., of the University of Michigan Program in Sexual Rights and Reproductive Justice. She also thanks all Michigan midwives and consumers advocating for CPM licensure and other choices in childbirth; as well as two national organizations that show us the way: The Big Push for Midwives and Legal Advocates for Birth Options and Rights.

1. **Obstetrician-gynecologists** are medical doctors who specialize in women's reproductive health. For the purpose of this article, these physicians are referred to as "OBs," representing the part of their specialty that deals primarily with pregnancy and childbearing. Following the usual medical course of education, future OBs undertake an additional four-year specialized residency, after which they seek certification from the American Board of Obstetrics and Gynecology through oral and written examination. See *Frequently Asked Questions (FAQs)*, AM. BD. OBSTETRICS & GYNECOLOGY, <http://www.abog.org/faq.asp#what> (last visited Jan. 23, 2013). OBs may, if they choose, seek further specialization in fields such as maternal-fetal medicine or gynecologic oncology through a three-year fellowship and additional certification. *Id.* Like other physicians, OBs are licensed by the state. MICH. COMP. LAWS § 333.17011 (2006).

Certified Professional Midwives (CPMs), on the other hand, may seek licensing in twenty-seven states and hold varying status in the remaining states. See *infra* notes 14, 43. CPMs are certified by the North American Registry of Midwives; their "competency is established through training, education and supervised clinical experience, followed by successful completion of a skills assessment and written exam." *How to Become a CPM*, ORG, <http://narm.org/certification/how-to-become-a-cpm/> (last viewed Jan. 30, 2013). See also NORTH AMERICAN REGISTRY OF MIDWIVES,

consumers and CPMs currently support legislation that would add Michigan to the twenty-seven states that provide licensure for non-nurse midwives.² Women in the United States have been choosing out-of-hospital birth at an increasing rate in recent years.³ In the face of this increase, and because CPM practice is neither licensed nor specifically proscribed in Michigan, CPMs and their patients look forward to a more certain legal posture post-licensure.⁴ Understanding that posture

CERTIFIED PROFESSIONAL MIDWIFE: RECOGNIZING A VALUED MATERNITY CARE PROVIDER 7 – 10 (2012) *available at* http://narm.org/wp-content/uploads/2013/01/NARM%20policy%20brief_2pager010613.pdf (presenting an updated “Policy Brief that focuses on the competency based certification model for health professions.”). CPMs share both similarities and differences with **Certified Nurse Midwives** (CNMs), who are discussed in greater detail. *See infra* SUBORDINATION. CNMs are licensed in Michigan as nurses; they complete an additional specialty in midwifery, administered by the American College of Nurse Midwives and likewise recognized by statute. MICH. COMP. LAWS § 333.2701 (1990); *see also* *About ACNM*, AM. COLL. NURSE MIDWIVES, <http://www.midwife.org/index.asp?sid=19> (last visited Jan. 23, 2013); MICH. ADMIN. CODE r. 338.10404 (2003).

2. Michigan CPM licensure bills introduced in 2011 and 2012 did not survive the legislative session, but may be re-introduced in the new session. *See* H.B. 5070, 96th Leg., Reg. Sess. (Mich. 2011) *and* S.B. 1310, 96th Leg., Reg. Sess. (Mich. 2012).

3. U.S. home births increased by 29% from 2004 to 2009, from a total of 0.56% to 0.72% of all U.S. births. Marian F. MacDorman et al., *Home Births in the United States, 1990-2009*, CDC, NCHS Data Brief No. 84 (Jan. 2012) *available at* <http://www.cdc.gov/nchs/data/databriefs/db84.pdf>. This article, *Baby Steps*, is premised on the evidence-based finding that out-of-hospital birth is as safe, if not safer, for low-risk pregnant women and their babies when compared with hospital birth. *See* Kenneth C. Johnson & Betty-Anne Daviss, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BRIT. MED. J. 1416 (2005); *see* Kenneth C. Johnson & Betty-Anne Daviss, *Neonatal Mortality Risks Similar in Careful Comparison of the CPM2000 and the 2004 U.S. Neonatal Mortality among Term Births to non-Hispanic White Women, but Prematurity Lower with Midwives*, UNDERSTANDING BIRTH BETTER, *available at* <http://understandingbirthbetter.com/section.php?ID=24&Lang=En&Nav=Section>. An unpublished survey of other studies can be found at the Midwives Alliance Division of Research webpage. Saraswathi Vedam et al., *Home Birth: An Annotated Guide to the Literature*, MIDWIVES ALLIANCE DIVISION OF RESEARCH (May, 2011), <http://www.bcmidwives.com/files/Home%20Birth%20Annotated%20guide%20to%20the%20literature%20May%202011.pdf> (as this source will be updated periodically, follow mana.org/DOR/research-resources/).

4. *See* David M. Eisenberg et al., *Credentialing Complementary and Alternative Medical Providers*, 137 ANNALS INTERN. MED. 965, 970 (2002) (“Providers who lack

involves questioning the current relationship CPMs experience with OBs, and their possible future relationships.

This article examines the legal and institutional factors that shape the OB-CPM relationship in Michigan, with comparisons to two neighboring states, Indiana and Wisconsin, as well as a more distant jurisdiction, the Netherlands. Specifically, this article asks: should Michigan CPMs attain licensure, what relationship with OBs might result - *Exclusion, Coexistence, Subordination* or *Cooperation*? How might factors in addition to licensure – medical malpractice liability, liability insurance availability, scope of practice determinations, hospital transfer protocols, private health care insurance, and Medicaid coverage – shape the relationship? This article will analyze the four possible relationships in light of these factors and suggest both expected and aspirational outcomes. The article concludes with the appreciation that post-licensure CPMs must attain a relationship of cooperation with OBs, while retaining their own professional autonomy.

EXCLUSION

The history of women's birth choices provides a backdrop to the eventual relationship of exclusion between OBs and CPMs. Indiana law illustrates this relationship.

TRADITIONAL MIDWIFERY

In the beginning, *all* birth was home birth. Certainly, it is recorded that in the United States from the Colonial Era until the late eighteenth century, midwives attended births in mothers' homes.⁵ The displacement of midwives by physicians began in the late eighteenth century as a result of patient choice and an

licensure share a complex and uncertain legal status. . . . Many . . . have historically been prosecuted and convicted for the unlicensed practice of medicine . . .").

5. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 49–50 (1982); *see also generally*, RICHARD W. WERTZ & DOROTHY C. WERTZ, *LYING-IN: A HISTORY OF CHILDBIRTH IN AMERICA* (1977).

individual and collective effort by physicians.⁶ This friction occurred in the emerging context of the rise of physician status, the broader struggle for dominance between several schools of medical thought,⁷ and widespread physician opposition to the admission of women to medical schools.⁸ The period between 1910 and 1930 was particularly notable for its anti-midwife campaigns carried out by medical societies and the commensurate drop in the percentage of births attended by direct entry midwives (DEMs). DEMS were characterized as "lay"⁹ midwives, a category that included both immigrant midwives trained in their home countries and "granny" midwives from the American South.¹⁰ By the late 1960s, over ninety-nine percent of United States births took place in hospitals.¹¹ This consumer swing followed reforms that increased general safety and promoted the centralization of

6. STARR, *supra* note 5, at 49 – 50.

7. *Id.* (For example, Thomsonians, homeopaths, and allopaths).

8. *Id.*; see also generally Gerald E. Markowitz & David Karl Rosner, *Doctors in Crisis: A Study of the Use of Medical Education Reform to Establish Modern Professional Elitism in Medicine*, 25 AM. Q. 83 (1973) (discussing, in more depth, each factor and its eventual effect on modern medical practice).

9. The term "direct entry midwife" (DEM) is used in this article to indicate any midwife whose practice does not require a university degree. CPMs are the most prevalent kind of DEM in the United States. Because CPMs are trained and certified, by definition they are not "lay."

10. Professor Stacey Tovino points out that the practice of midwifery was permitted for African-American women much longer than for white women, most likely because of combined racist and economic motives. In Alabama, for example, "granny" midwives (African-American midwives, now more properly called "grand" midwives) provided care for their impoverished communities that, nevertheless, produced better neonatal and maternal outcomes than did their white physician counterparts in wealthier communities. Nevertheless, when public health infrastructure developed sufficiently to pay granny midwives more than nominal sums, physicians were quick to characterize midwives as dirty, unsafe, and uneducated. Physicians parlayed their own political power into influence with state legislatures and public health institutions to legally block midwives from practicing. See Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 74–77 (2004).

11. ROBBIE DAVIS-FLOYD & CHRISTINE BARBARA JOHNSON, *MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE* 61 (2006).

many formerly dispersed services in hospitals.¹² Most relevant to the gradual disappearance of out-of-hospital midwife care was the redefinition of childbirth as a disease, for which the cure was medicine and technology.¹³ Some states went so far as to criminalize the practice of direct entry midwifery.¹⁴ In fact, nine states still retain these criminal statutes.¹⁵

Until the 1970s, the small number of home births that continued to take place were largely associated with poor or rural women, or women without access to hospital care.¹⁶ However, that decade saw a significant increase of a new kind of planned home birth – those arranged by middle-class, often well-educated, women who were discontented with the medical model of childbirth or desired a home birth for cultural or religious reasons.¹⁷ These women had the means to search out skilled childbirth attendants of a different kind; such attendants rose to the occasion and flourished largely independent of the medical profession.¹⁸

12. JUDITH PENCE ROOKS, *MIDWIFERY AND CHILDBIRTH IN AMERICA* 52 – 56 (1997).

13. Eugene Declercq et al., *Where to Give Birth? Politics and the Place of Birth*, in *BIRTH BY DESIGN: PREGNANCY, MATERNITY CARE, AND MIDWIFERY IN NORTH AMERICA AND EUROPE* 8 – 9 (2001).

14. Midwives Alliance of North America, *Direct Entry Midwifery State-by-State Legal Status*, MANA.ORG, <http://mana.org/statechart.html> (last updated May, 2011) [hereinafter MANA, *Legal Status*] (showing that direct entry midwifery remains expressly criminalized in nine states and the District of Columbia). For example, the North Carolina code states, "[n]o person shall practice or offer to practice or hold oneself out to practice midwifery unless approved pursuant to this Article." N.C. GEN. STAT. § 90-178.3(a) (2005). Only nurse-midwifery is approved by this Code. N.C. GEN. STAT. § 55B-14(c)(2) (2007). See also *PushChart*, PUSHFORMIDWIVES.ORG, http://pushformidwives.org/wp-content/uploads/2012/05/State-Regulation-Chart_APRIL-2012.pdf (last updated Apr. 29, 2012) (outlining the various states of CPM regulations throughout the United States).

15. MANA, *Legal Status*, *supra* note 14 (showing that direct entry midwifery remains expressly criminalized in nine states and the District of Columbia).

16. WERTZ & WERTZ, *supra* note 5, at 47.

17. ROOKS, *supra* note 12, 54 – 56.

18. *Id.* at 61. Most famous of these midwives is Ina May Gaskin of The Farm Midwifery Center, in Tennessee, who has been attending births for forty years with exemplary outcomes. See generally INA MAY GASKIN, *BIRTH MATTERS: A MIDWIFE'S MANIFESTA* (2011) (supplying more information on Ina May Gaskin).

CERTIFIED PROFESSIONAL MIDWIVES

These skilled childbirth attendants evolved into CPMs, a national credential created in 1986 by the newly organized Midwives Alliance of North America (MANA).¹⁹ The North American Registry of Midwives (NARM) took up responsibility for administering the certification. "In 2001, the National Association of Certified Professional Midwives (NACPM) was created to articulate the philosophy and principles of practice and to establish standards of practice specific to CPMs."²⁰ The CPM philosophy is

to work with women to promote a healthy pregnancy, and provide education to help her make informed decisions about her own care. In partnership with their clients they carefully monitor the progress of the pregnancy, labor, birth, and postpartum period and recommend appropriate management if complications arise, collaborating with other healthcare providers when necessary.²¹

This philosophy is grounded in evidence-based care, informed consent doctrines,²² and a belief in the Midwives Model of Care.²³

MEDICAL REACTION

Beginning in the nineteenth century, and following the

19. *Certified Professional Midwives in the United States*, MANA.ORG at 3 (June 2008), <http://mana.org/pdfs/CPMIssueBrief.pdf>.

20. *Id.*

21. *What is a CPM?*, NARM.ORG, <http://narm.org> (last viewed Oct. 26, 2012).

22. *Id.*

23. See *The Midwives Model of Care*, CITIZENS FOR MIDWIFERY, <http://cfmidwifery.org/mmoc/define.aspx> (last visited Oct. 26, 2012)

(The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes: 1) Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; 2) Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support; 3) Minimizing technological interventions; and 4) Identifying and referring women who require obstetrical attention.)

1930s, OBs have objected to midwives as birth attendants in out-of-hospital settings.²⁴ Their expressed concern has been for the safety of pregnant women and babies in the hands of non-medical practitioners.²⁵ In 2008, the American Medical Association (AMA) passed a series of resolutions in an attempt to target and restrict the practice of non-nurse midwives.²⁶ In 2011, the American Congress of Obstetricians and Gynecologists (ACOG), the premier professional organization for those specialties, issued a statement that conceded a woman's right under the doctrine of informed consent to give birth at home, but warned of safety concerns.²⁷

However, physicians' greatest ability to influence the accessibility of out-of-hospital birth is the use of political influence to restrict the availability of licensed midwives. State medical societies can effectively block midwife licensure bills,²⁸ and in states where midwives are already licensed, can narrow scope of practice regulations.²⁹ State medical societies and professional associations like the ACOG and the AMA wield

24. Bridget Richardson, *The Regulation of Midwifery*, 8 GEO. J.L. & PUB. POL'Y 489, 491 – 92 (2010).

25. *Id.*

26. *Id.* at 497.

27. Kristi L. Watterberg, *ACOG Statement Opens Door to Home Births: Pediatric Guidelines Needed on How to Counsel Parents, Care for Infants*, AAP NEWS, Apr. 2011, at 22, 22. ACOG claimed that, "planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared to planned hospital birth." *Id.* The science behind this assertion, a meta-analysis by Joseph Wax, has been broadly criticized both inside and outside the OB community. *Letters to the Editors*, AM. J. OBSTET. GYNECOL. e14–20 (Apr. 2011).

28. An internal ACOG memo cites a Missouri licensure bill as an example: "These [CPM licensure] bills have been stopped – up to now – mainly by deft political maneuvering and hardball tactics employed by the State Medical Society, not by any persuasive testimony about comparative safety or quality of care." *'Lay' Midwives & Home Birth: Troubling Trends in State Legislation*, ACOG STATE LEGISLATIVE UPDATE YEAR IN REVIEW 4 (2007).

29. See Amy Lynn Sorrel, *Scope of Practice Expansions Fuel Legal Battles*, AM. MED. NEWS (March 9, 2009), <http://www.ama-assn.org/amednews/2009/03/09/prl20309.htm>.

considerable power in both state and federal spheres.³⁰

A recent ACOG webinar declared its members' motivation in barring CPMs from practicing to be rooted in safety concerns, yet admitted there was data to suggest "high quality maternity outcomes by these low cost providers."³¹ In states that prohibit CPM licensure, the effort to exclude CPMs is quite successful. Additionally, on a national scale, physicians are deterred from working together with CPMs because medical liability insurance companies erect serious barriers to physicians providing back-ups to out-of-hospital birth attendants, including terminating

30. See Tom Christoffel, *Hiring on the Cheap: Health Care Costs, the Eclipse of Physicians and Change in Licensing Laws*, 4 ST. LOUIS U. PUB. L. REV. 57, 59 (1984) (noting that "[b]y the end of World War I, the American Medical Association had been transformed from an academic and scientific organization into a powerful guild representing the small businessman, medical practitioner."). See also Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273, 1308 (1996)

(Physician groups are a strong and wealthy lobbying force; the American Medical Association (AMA) has one of the largest political action committees (PACs) in the country, with many legislators on its political contribution list. In fact, the AMA was described in a 1993 article as the "undisputed king of PAC contributions" – distributing \$3.2 million in the 1991-1992 election cycle. As a result, state and federal regulations give virtual monopoly privileges to physicians and deprive consumers of the benefits of alternative health care professionals. When laws are adopted to legitimate some aspect of alternative care, they often include provisions to assure that physicians still get paid by requiring "physician supervision" and still retain control by enabling the licensing board dominated by physicians to determine what the alternative providers may or may not do.);

see RESOL. 204, AMA H.D., Apr. 28, 2008 (showing how the AMA attempts to institute its "Scope of Practice Partnership" by opposing licensure of CPMs and restricting scope of practice in existing licensed health professions); see AMA, *Mid-year Report of 2010 AMA Advocacy Achievements (YTD)* (June 2010), AMA-ASSN.ORG, <http://www.ama-assn.org/ama1/pub/upload/mm/399/hsr-2010-advocacy-accomplishments.pdf> (describing a list of AMA successes in narrowing the scope of practice for various professions).

Moreover, the Federal Trade Commission has implied that the "elimination of supervision and delegation requirements appears to be a procompetitive improvement in the law." Letter from FTC Staff, to Rodney Ellis & Royce West, Tex. State Senate (May 11, 2011) (on file with author), available at www.ftc.gov/os/2011/05/V110007texasaprn.pdf.

31. *December 8 HCR Webinar* (Dec. 8, 2010), at Slide 5, ACOG.ORG, http://www.acog.org/About_ACOG/ACOG_Departments/Health_Care_Reform (click December 8, 2010 transcript).

coverage of such physicians.³² Most physicians must, quite understandably, attempt to protect their fiscal health, particularly in connection with liability concerns.

These concerns arise most destructively when CPMs transfer patients to hospital care in cases where the patients have moved beyond the low-risk category most appropriate for out-of-hospital care, or have experienced labor complications of an urgent or emergent nature.³³ While CPMs are trained to identify such problems early and appropriately initiate transfers, such transfers are often physicians' only encounters with out-of-hospital birth, and thus disproportionately shape their understanding of its safety.³⁴ Since physicians are required to accept any patient who is in active labor³⁵ physicians may feel themselves to be locked into providing care in cases where they consider themselves to be at high risk for malpractice liability.

CASE STUDY: INDIANA

Indiana typifies jurisdictions that specifically criminalize the practice of direct entry midwifery, including as practiced by CPMs. The State's "Professions and Occupations" code permits

32. Andrews, *supra* note 30, at 1290 – 91.

Fellow physicians and institutions also impede the formation of relationships between physicians and out-of-hospital midwives. In 1990, the Sixth Circuit Court of Appeals effectively ruled that should physicians and hospitals join to deny coverage to other physicians who provide back-up to midwives, that action does not constitute an antitrust violation. See *Nurse Midwifery Assoc. v. Hibbett*, 918 F.2d 605 (6th Cir. 1990). Other courts reasoned "that a hospital and its medical staff – a creature of the hospital – do not engage in concerted action for the purposes of the antitrust laws." David P. Cluchey & Edward David, *Antitrust*, in *LEGAL MEDICINE* 49, 50 (2004) (summarizing several decisions).

33. See ROOKS, *supra* note 12, at 383 (estimating a 10 – 15% transport rate).

34. See Jeffrey Ecker & Howard Minkoff, *Home Birth: What Are Physicians' Ethical Obligations When Patient Choices May Carry Increased Risk?* 117 *OBSTET. & GYNECOL.* 1779, 1180 – 81 (2011).

35. 42 U.S.C. § 1395dd(b) (2010) (signifying that the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA) requires that hospital emergency rooms and labor and delivery departments accept any patient who is in active labor or suffering from an emergency medical condition).

licensing of nurse-midwives only³⁶ and punishes the practice of midwifery without a license as a Class D felony,³⁷ which carries a jail sentence of six months to three years and a possible added fine of up to \$10,000.³⁸ The state court of appeals conclusively held that “the practice of midwifery without a license would constitute the unauthorized practice of medicine.”³⁹

Unlicensed midwives nevertheless continue to practice, much in the manner described in Jennifer Block’s influential book, *Pushed*, in the chapter entitled simply, “Underground.”⁴⁰ Such midwives do not advertise publicly, as any internet search will reveal, nor does the Indiana Midwife Association display a list of practitioners.⁴¹ Prosecution of Indiana midwives is a real danger, with the most recent arrest having occurred in April 2012 of a midwife who served the Amish community, among others.⁴²

36. IND. CODE § 25-23-1-13.1(a) (1996).

37. IND. CODE § 25-22.5-8-2(b) (2007) (“A person who practices midwifery without the license required under this article commits a Class D felony”).

38. IND. CODE § 35-50-2-7(a) (2012). Although Class D felonies may be converted to Class A misdemeanors, which carry much lighter sentences, this option is not available to those “convicted of a Class D felony that resulted in bodily injury to another person.” IND. CODE § 35-50-2-7(c)(2) (2012).

39. *Smith v. State ex rel. Medical Licensing Bd.*, 459 N.E.2d 401, 405 (Ind. Ct. App. 1984).

40. See JENNIFER BLOCK, *PUSHED: THE PAINFUL TRUTH ABOUT CHILDBIRTH AND MODERN MATERNITY CARE* 177-212 (2007). See generally Lisa Koers, *Benefits of Midwifery for Low-Income Women* 28 – 9 (Apr. 23, 2008) (unpublished undergraduate thesis), available at <http://www.poynter.indiana.edu/publications/rs-koers.pdf> (giving more information about Indiana’s underground midwifery).

41. INDIANA MIDWIFES ASSOCIATION, <http://www.indianamidwivesassoc.com/> (last visited Oct. 18, 2012).

42. Patrick Redmond, *LaGrange County Arrest of Howe Woman Revives Midwife Debate*, IND. ECON. DIGEST, Apr. 15, 2012, <http://www.indianaeconomicdigest.net> (follow “most recent”; then click “by topic”; follow “health care”). See generally Jennifer Margulis, *Arrested Midwife Says She Won’t Deliver Babies in Indiana Anymore*, JENNIFER MARGULIS BLOG (Apr. 13, 2012), <http://jennifermargulis.net/blog/2012/04/arrested-midwife-says-she-won%E2%80%99t-deliver-babies-in-indiana-anymore/> (giving more background on this story).

EXCLUSION SUMMARY

The relationship of *Exclusion* results from a tension between styles and locations of practice, disagreement regarding scientific bases of safety, and divergent economic interests. The relationship, at its extreme, is marked by criminalization of direct entry midwifery, as in Indiana. This is hardly an ideal relationship, as it inhibits the development of formal mechanisms for transfer of patients from CPMs to OBs, while providing every incentive for CPMs to resist such transfers. In addition, patient choice of practitioner – and thus also place of birth – is severely restricted. The only advantage of *Exclusion* is that the practitioners' legal rights are brutally clear.

COEXISTENCE

Coexistence is the state of the law in jurisdictions that do not expressly forbid or criminalize the unlicensed practice of midwifery; however, they do not offer any legal protections, such as licensure or statutory practice agreements. Practitioners in such states occupy a legal status that appears to be ill-defined, allowing them to practice without interference; this freedom, however, may well be illusory.

CASE STUDY: MICHIGAN

Michigan is one of twenty-three states that do not license CPMs;⁴³ therefore, CPMs who practice in Michigan do so without most legal protections. The basis for the minimal protections that are assumed to exist is the 1939 case, *People v. Hildy*, 286 N.W. 819 (Mich. 1939), in which the Michigan Supreme Court interpreted the relevant statute to mean that the practice of midwifery was not the practice of medicine.⁴⁴ Under

43. *Legal Status of CPMs State by State*, PUSHFORMIDWIVES.ORG, <http://pushformidwives.org/cpms-by-state/> (last visited Oct. 27, 2012).

44. *People v. Hildy*, 286 N.W. 819, 821 (Mich. 1939) (The statute in question was part of the 1929 Public Health Act. The comparable current statute is MICH.

this interpretation, unlicensed midwives could not be prosecuted for the unauthorized practice of medicine or nursing. The *Hildy* court relied upon a twenty-five-year-old opinion of the Michigan Attorney General, stating that while midwifery combined with the practice of medicine or surgery constituted the practice of medicine, midwifery practiced alone did not.⁴⁵ *Hildy* has not been expressly overruled; however, its ability to protect unlicensed midwives is dubious given its combined reliance on an Attorney General's opinion,⁴⁶ which is not considered binding law, and a version of the Public Health Act that is no longer in force.⁴⁷

In addition, because Michigan midwives are unlicensed, should an injury occur to a patient for which a midwife is culpable, the patient cannot file a disciplinary report with a state licensing board, which might lead to civil disciplinary action. Instead, the patient's only recourse is in tort law, or in convincing a prosecutor to file criminal charges. Given most CPMs' low personal incomes⁴⁸ and low or nonexistent liability insurance coverage,⁴⁹ tort actions would seem to offer little chance of recovery.

When midwives experience bad outcomes, particularly in

COMP. LAWS § 333.17011 (1985), part of the Public Health Code of 1978.). States have come to different conclusions as to whether midwifery is the practice of medicine or nursing, either because of substantive differences in those respective practices from one state to another, or possibly because of selected states' interest in encouraging direct entry midwifery in order to provide care for indigent or rural populations. See, e.g., *State Bd. Nursing v. Ruebke*, 913 P.2d 142 (Kan. 1996).

45. *Hildy*, 286 N.W. at 821.

46. *Id.*

47. *Id.* at 820.

48. Although income statistics for CPMs are hard to locate, one midwifery advocacy organization compares the known salary range of CNM's (\$30,000-\$80,000) to that of direct entry midwives (DEMs), which include CPMs. The organization posits that "[f]or DEMs the income range generally is lower, and depends on factors like the location (urban or rural), which state (legal or not, insurance coverage or not), and how many births a DEM does in a given period of time." *Frequently Asked Questions About Midwives and Midwifery*, CITIZENS FOR MIDWIFERY, <http://cfmidwifery.org/midwifery/faq.aspx> (last visited Oct. 26, 2012).

49. See *infra* MALPRACTICE LIABILITY.

the event of a baby's death, prosecutors are often eager to bring criminal charges for offenses ranging from child abuse to involuntary manslaughter, even if the baby's family is opposed.⁵⁰ In Michigan, as in most states, where involuntary manslaughter is a felony,⁵¹ such charges – even absent an ultimate conviction – can bring a midwife's career to an end and ruin her financially. In fact, even the fear of criminal charges can adversely affect the care midwives give their patients. A midwife typically comes to the attention of authorities when she transfers to a hospital a patient in need of more intensive medical attention. At that point hospital personnel, if under the impression "something improper was done," may feel responsible for reporting the midwife to law enforcement agents.⁵² Midwives' incentive to transfer patients immediately plummets, as questions will loom as to whether a patient's condition is serious enough to warrant the potential loss of career, financial stability, and, her freedom.

COEXISTENCE SUMMARY

The state of *Coexistence*, however reassuringly peaceful it may seem on the surface, gives all power to the OB, the hospital, and the state. Although Michigan midwives often refer to their

50. For example, a midwife in Pennsylvania, where only nurse-midwives may be licensed, was charged with felony involuntary manslaughter. A local midwife advocacy group leader stated, "[t]he majority of midwives licensed by the state don't do home births. . . . We'd rather see the state study ways to see that mothers have more access to options, rather than prosecute a case that the parents don't want to see prosecuted." David Conti, *Midwife Charged in Baby's Death*, PITTSBURGH TRIBUNE-REVIEW, Apr. 23, 2004, at A1.

51. MICH. COMP. LAWS § 750.321 (1931).

52. Raymond G. de Vries, *The Trap of Legal Recognition*, in MIDWIFERY AND THE MEDICALIZATION OF CHILDBIRTH: COMPARATIVE PERSPECTIVES 309, 314 (1999)

(Where there are no clear regulations governing the practice of midwifery, an "uneasy truce" between midwives and the medical community continues: midwives are free to practice until they attract the attention of medical professionals. If a client of a midwife comes to the attention of a physician and the physician believes something improper was done, then the law is invoked as a regulatory mechanism and courts become the arena of regulation.).

practice as “a-legal,”⁵³ in truth, their practice is, at best, “legally ambiguous”⁵⁴ – and that condition persists only until the midwife’s first bad outcome.

SUBORDINATION

Subordination is another possible post-licensure relationship between Michigan CPMs and OBs. In this relationship, the status of the Certified Nurse Midwife (CNM) offers a cautionary tale.

CERTIFIED NURSE MIDWIVES

At the beginning of the twentieth century, just as DEM numbers dwindled, the nurse-midwife was introduced, first in Appalachia through the Frontier Nursing Service, and later through schools of midwifery designed to educate nurse-midwives to serve impoverished urban areas.⁵⁵ Nurse-midwife care was required to be provided under the supervision of a physician; however, nurse-midwives practiced with varying degrees of independence, depending on state law, remoteness of the location, and many other factors.⁵⁶ Beginning in the 1950s, in parallel with the general change from home birth to hospital birth discussed earlier, nurse-midwives gradually also relocated to the hospital setting. The CNM credential, certified through the American College of Nurse-Midwives, was introduced in 1971.⁵⁷ Although Michigan CNMs may attend out-of-hospital births, in practice very few do so, as their legal scope of practice

53. *All About Michigan Midwives*, CENTER FOR THE CHILDBEARING YEAR, <http://center4cby.com/types-of-midwives.html> (last visited Oct. 27, 2011) (“The practice is considered ‘a-legal’ in that it is neither prohibited by law nor sanctioned by the state.”).

54. Irene H. Butter & Bonnie J. Kay, *State Laws and the Practice of Lay Midwifery*, 78 AM. J. PUB. HEALTH 1161, 1162 (1988).

55. See ROOKS, *supra* note 12, at 36.

56. *Id.*

57. *Certification of Midwives*, AM. COLL. NURSE MIDWIVES, http://www.midwife.org/siteFiles/education/Certification_of_Midwives_7_09_000.pdf (last visited Oct. 27, 2012).

arguably requires a supervisory or collaborative relationship with a physician.⁵⁸ Individual physicians who wish to provide such an association are frequently prevented from so doing by the policies of their hospitals, malpractice carriers, or by the censure of their peers.⁵⁹

Michigan CNMs may attend hospital births, operate birth centers,⁶⁰ and even prescribe certain medications;⁶¹ however, their scope of practice is strictly controlled by their authorizing physician, who by “written, predetermined procedures or protocols . . . speci[fies], among other things, when his/her presence is required and when it is not.”⁶² Women who choose care by a CNM in order to avoid what they consider to be the excessive medicalization of pregnancy associated with physician care, may find themselves unpleasantly surprised by the degree to which CNMs are bound to adhere to physician or institutional

58. In the case of a nurse-midwife delivering an infant at a hospital, a scope of practice guide opines: “If the birth were normal, an OB-GYN generally would review and approve the . . . [nurse-midwife’s] work, but if the delivering woman exhibited signs of hemorrhage or any other harmful condition, the OB-GYN would be called in to supervise directly or handle the situation.” The guide continues by noting that even should the nurse-midwife deliver the baby out-of-hospital in independent practice, “standard practices dictate that an informal supervisory relationship with a physician exist, mainly for consultation or referral in case of an emergency. Usually such a relationship also entails the doctor reviewing and signing off on certain activities.” Peter Pratt & Lisa Katz, *Scope of Practice of Health Professionals in the State of Michigan*, MICH. STATE MED. SOCIETY 1, 39 (2001), available at <http://www.msms.org/Content/ContentFolders/Advocacy2/ScopeofPractice/ScopePracBook.pdf> (last visited Feb. 6, 2013).

59. Rixa Ann Spencer Freeze, *Attitudes Towards Home Birth in the USA*, 5 EXPERT REV. OBSTET. GYNECOL. 283, 287 (2010).

60. At the time of this writing, there is only one independent Michigan birth center staffed exclusively by CNMs. MOTHER’S OWN BIRTH, <http://www.mothersownbirth.com/about-us/staff/> (last visited Jan. 24, 2013). Interestingly, the states of New Mexico, Wyoming, and West Virginia have recently experienced an increase in CNM-attended births. Eugene Declercq, *Midwife-Attended Births, 1989 to 2007*, 56 J. MIDWIFERY WOMEN’S HEALTH 173, 173 (2011).

61. Pratt & Katz, *supra* note 58, at 1, 22. One sign of CNM dissatisfaction with current restrictions on their practice is the recent re-introduction of an advanced practice nursing bill that offers CNMs and other types of advanced practice nurses the ability to practice more autonomously. S.B. 2, 97th Leg., Reg. Sess. (Mich. 2013).

62. Pratt & Katz, *supra* note 58, at 37.

protocols. This observation is not intended to suggest there is no benefit to the care that CNMs deliver, merely that they can hardly be considered independent practitioners as a matter of law and regulation.

CNM-CPM CONVERGENCE – ACA BIRTH CENTER COVERAGE

On the other hand, by virtue of their philosophy of practice and birth,⁶³ CNMs enjoy a natural affiliation with CPMs, a fact acknowledged by ACOG when it named the CNM a “fickle ally” in ACOG’s fight against CPMs:⁶⁴

[t]he American College of Nurse-Midwives (ACNM) and its state chapters are divided on their response to state legislation that would license CPMs and legalize home birth. This complicates ACOG’s advocacy. Whereas nurse-midwives have been ACOG’s front-line defense against these bills, that’s no longer a sure thing. Today, you don’t see nurse-midwives speaking with any consistency against home birth or the certified professional midwives (CPMs).⁶⁵

Indeed, from ACOG’s perspective, recent law would seem to be leading CNMs further into the outer orbit of physician oversight and more closely into the arms of their CPM colleagues. The Patient Protection and Affordable Care Act of

63. The Midwives Alliance of North America’ Bridge Committee promotes dialog and understanding between CNMs and midwives with other credentials. *MANA-ACNM Bridge Club*, MANA.ORG, <http://mana.org/bridgeclub.html> (last visited Oct. 27, 2012). MANA formulated the “Midwives Model of Care” paradigm, which begins with the premise that pregnancy and birth are natural life processes, and goes on to define four key characteristics of midwife care. *The Midwives Model of Care*, CITIZENS FOR MIDWIFERY, <http://cfmidwifery.org/mmoc/define.aspx> (last visited Oct. 27, 2012).

64. ACOG’s statement has since been eliminated from the web. This NARM online newsletter mentions the ACOG statement with a, now inoperable, link. Ida Darragh, *From the NARM Chair*, N. AM. REGISTRY MIDWIVES NEWS, Summer, 2008, at 2, available at <http://www.narm.org/pdf/2008SummerNews.pdf>.

65. As the site is now inoperable, the editors have found a blog that claims to quote ACOG’s statement. Human_Being<3, *ACOG’s 2007 Midwifery Year in Review: OB/GYNs Strategy Against Midwives & Homebirth*, MOTHERING (June 7, 2008, 5:21 PM), <http://www.mothering.com/community/t/911190/acogs-2007-midwifery-year-in-review-ob-gyns-strategy-against-midwives-and-homebirth>.

2010 (ACA) incorporated the 2009 Medicaid Birth Center Reimbursement Act, which mandated state and federal Medicaid coverage of birth centers.⁶⁶ It repaired a defect of an earlier Health and Human Services administrative ruling, which permitted Medicaid reimbursement only of midwife fees, but not birth center facility fees.⁶⁷ With the latter coverage now mandated,⁶⁸ it becomes more practicable for CNMs to operate independent birth centers. The ACA also removed a limit on CNM Medicaid fees, which formerly limited CNMs reimbursement to a maximum sixty-five percent of the fee a physician might receive. CNMs can now be reimbursed up to one hundred percent of a physician's fee.⁶⁹ In addition, the ACA extends the definition of birth attendant to "nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Secretary."⁷⁰ This mandates Medicaid reimbursement for birth centers staffed by CPMs, contingent on individual state licensing and regulation, opening possibilities for CNM/CPM cooperation.

Medicaid payment for out-of-hospital providers is a logical area of inquiry when one considers the large percentage of Michigan births funded by Medicaid – fifty-one percent in 2010.⁷¹ From 2008 to 2009, an uncomplicated Michigan hospital birth was billed on average at between \$7,428 and \$14,353; these figures represent facility fees only and do not include

66. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119, 292 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (to be codified primarily in scattered sections of 42 U.S.C.).

67. Hearing Notice: Reconsideration of Disapproval of Texas State Plan Amendment (SPA) 07-011, 73 Fed. Reg. 15528 – 29 (Mar. 14, 2008) (describing the original ruling).

68. PPACA, Pub. L. No. 111-148, 124 Stat. 119, 292 (2010).

69. PPACA, Pub. L. No. 111-148, 124 Stat. 119, 423 (2010).

70. PPACA, Pub. L. No. 111-148, 124 Stat. 119, 292 (2010).

71. PowerPoint: Steve Fitton, Presentation, *The Future of Medicaid* to the Capital Area Health Alliance, slide 7 (Dec. 7, 2011), *available at* www.cahealthalliance.org/docs/Fitton.pdf.

professional fees.⁷² Statistics for Michigan home birth costs are not readily available; however, one birth organization suggests a range of \$1,000 to \$4,000 to cover all services associated with a birth.⁷³ Should state government permit Medicaid recipients to utilize home birth providers, the savings to the state could be considerable. This idea is especially attractive in light of the dearth of OBs in many rural and poor parts of Michigan⁷⁴ where out-of-hospital midwives could more easily establish practices to fill the gap, with no competition from OBs or hospitals. It is important to note that Medicaid inclusion of licensed midwives converges with the ACA's Provider Non-Discrimination Clause, which forbids private insurers from discriminating against any class of licensed provider.⁷⁵

SUBORDINATION SUMMARY

The increase in CNM independence resulting from the ACA, and the sometime political alliances with CPMs, bring CNMs and CPMs to a convergence of interests. However, CNMs remain dependent on physicians for authorization to work. No matter how congenial or collegial such relationships may be at times, ultimate authority still rests with physicians. This coexistence relationship, however pleasant in theory, does not represent the best exemplar for the future CPM-OB

72. Mich. Health & Hosp. Ass'n. (MHA), *Hospital Charge Information*, MI HOSPITAL INFORM: PRICE AND QUALITY DATA, <http://www.mihospitalinform.org/SelectMdcDrg.aspx> (follow the link; then select "Pregnancy and Delivery" as the MDC; also select "Vaginal delivery w/o complicating diagnoses" as the DRG) (last visited Oct. 29, 2012).

73. *All About Michigan Midwives*, CENTER FOR THE CHILDBEARING YEAR, <http://center4cby.com/types-of-midwives.html> (last visited Oct. 27, 2011).

74. MDCH, HEALTH PROFESSIONAL SHORTAGE AREAS FOR OBSTETRICAL AND GYNECOLOGICAL SERVICES, 95-1, Reg. Sess., (Mich. 2010), *available at* http://michigan.michigan.gov/documents/mdch/729_12_01_10_345537_7.pdf. (stating that the Michigan Department of Community Health identified 58 counties with insufficient or no obstetrical care). *See also* Ron French, *Sorry, Baby: Delivery Docs in Short Supply Up North*, BRIDGE, (July 19, 2012), <http://bridgemi.com/2012/07/sorry-baby-delivery-docs-in-short-supply-up-north/>.

75. PPACA, Pub. L. No. 111-148, 124 Stat. 119, 160 (2010).

relationship because of its lack of CPM autonomy.

COOPERATION

The final possible post-licensure relationship between CPMs and OBs is *Cooperation*, defined here as structural integration of the parties by means of a formal protocol for interaction between them. Reaching beyond mere licensure to issues of culture and law, CPMs and OBs must cooperate in ways governed by statute and regulation, while, simultaneously, considering liability and health care insurance coverage. A description of Wisconsin's midwife licensure act provides one example of cooperation, while an examination of maternity care in the Netherlands furnishes additional inspiration.

REGULATORY PROVISIONS

In order to achieve cooperation with OBs, CPMs must be governed by a body of regulation that delineates their scope of practice. This will make clear to CPMs, their clients, state law enforcement, and the courts what CPMs may and may not do. This regulation should define: 1) the risk assessment and categorization necessary for all patients considering an out-of-hospital birth; 2) guidelines for all stages of pregnancy, birth and post-partum care in and out-of-hospital settings; and 3) criteria and protocols for transferring care of patients should an emergency develop. This last item must be matched by regulations governing the other side of the interchange, so that hospitals and physicians can formally accept patients transferred by CPMs.

Licensure bills in other states have acknowledged the comprehensive maternity care offered by CPMs by permitting them to administer oxygen and inject anti-hemorrhagic medication when needed, and by requiring training in

cardiopulmonary resuscitation and newborn care.⁷⁶ In the early days of DEM licensing, it was common to see midwives regulated and monitored by a state's public health department. "This is in contrast to the conventional situation in which health occupations have their own regulatory board, consisting of members of their own occupation, and where licensure is administered by a department of licensure and regulation."⁷⁷ To maintain the values and methodology of CPM practice, as set out in the Midwives Model of Care,⁷⁸ it is critical that CPM licensing boards be populated primarily by CPMs in order to minimize the risk of CPM subordination by OBs.⁷⁹ Fortunately, Michigan's constitution requires that a majority of the members of a licensing board be members of that profession.⁸⁰

In the spirit of cooperation, every effort should be made to ensure that both CPMs and hospital-based birth attendants learn from one another:

Lessons learned from the integration of midwifery in Canada and other international settings include the need to have midwives participate actively in the community of maternity practice. All midwives should be able to access hospital admission privileges appropriate to their scope; participate in quality-assurance committees, clinical and academics teaching, and academic rounds; and attend women across birth settings. Clear protocols, vetted across all disciplines, should be established for communication between professionals when labor and delivery is in progress at home and for transport and hospital triage. Clinical and didactic education should prepare all maternity professionals for their respective roles in supporting safe and compassionate care regardless of planned

76. Kate Tormey, *The Health Care Workforce: In Critical Condition?*, FIRSTLINE MIDWEST, Dec. 2010, at 1, 3.

77. Butter & Kay, *supra* note 54, at 1165.

78. *See supra* note 23.

79. *See discussion supra* SUBORDINATION.

80. MICH. CONST. art. V, § 5.

place of birth.⁸¹

In addition, standard features of licensed medical practice should be equally available to licensed CPMs; these would include “peer review, attendance at continuing-education programs, regular recertification, and transparent avenues for vetting complaints, grievances, and case review.”⁸²

MALPRACTICE LIABILITY

Malpractice liability is a heated and hated topic for OBs and other physicians.⁸³ President George W. Bush echoed this view in 2005,⁸⁴ and President Obama repeated it in 2011.⁸⁵ It is hardly

81. Saraswathi Vedam, et al., *Science and Sensibility: Choice of Birth Place in the United States*, MEDSCAPE OB/GYN & WOMEN’S HEALTH at 2 (Feb. 25, 2010), available at <http://www.medscape.com/viewarticle/717516>.

82. *Id.*

83. William M. Sage, *Over Under or Through: Physicians, Law, and Health Care Reform*, 53 ST. LOUIS U. L.J. 1033, 1043 (2008-2009) (“[H]atred of malpractice law and support for “tort reform” is a sustaining issue for all sorts of physician groups, whether social gatherings and medical staff meetings or county, state, and national medical societies.”). Physicians’ anxiety is understandable in the context of the Employee Retirement Income Security Act (ERISA), which effectively prevents injured plaintiffs from being made whole in suits against Managed Care Organizations. See M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 401 (2009). It seems reasonable, therefore, for physicians to suspect that plaintiffs will instead bring those suits against their individual health care providers.

84. *President Bush Proposes Medical Malpractice Reform* (PBS NewsHour television broadcast, Jan. 5, 2005), available at http://www.pbs.org/newshour/bb/health/jan-june05/malpractice_1-5.html

(Lawyers are filing baseless suits against hospitals and doctors. That's just a plain fact. And they're doing it for a simple reason: They know the medical liability system is tilted in their favor. Jury awards in medical liability cases have skyrocketed in recent years. It's a system that is just not fair, it is costly for the doctors, it's costly for small businesses, it's costly for hospitals; it is really costly for patients.)

85. State of the Union, 2011 DAILY COMP. PRES. DOC. 47 (Jan. 25, 2011). President Obama agreed that he was “willing to look at other ideas to bring down costs, including one that Republicans suggested last year – medical malpractice reform to rein in frivolous lawsuits.” *Id.* This language is featured in the AMA’s publication on medical liability. AMA, *Medical Liability Reform - Now!*, MLR – NOW!, 2012, at 1, 3 available at <http://www.ama-assn.org/resources/doc/arc/mlr-now-2011.pdf>. Many scholars and advocates have questioned the truth of these assertions. Insurance law scholar Tom Baker pointed out that fewer than 4% of

surprising that malpractice liability is a concern for OBs and policy makers with respect to licensed CPM practice. Two specific matters often raised are malpractice liability coverage for CPMs and vicarious liability of OBs for CPM actions.

The question often arises whether CPM licensing statutes should require CPMs to carry liability insurance. Very few states require physicians to carry insurance as a condition of licensing, although insurance is often a precondition to obtaining hospital privileges, or employment in a medical group practice.⁸⁶ Equally, few states that have licensed CPMs require them to carry liability insurance.⁸⁷ Currently, there is merely one national liability insurance plan available to out-of-hospital birth attendants.⁸⁸ Several states maintain joint underwriters associations like New York's Medical Malpractice Insurance Association, which must insure any licensed physician who is not able to obtain other coverage.⁸⁹ Such associations can be used to insure any midwives who attend out-of-hospital births, but the plan's usefulness depends on how premiums are computed and their consequent affordability.⁹⁰ It is worth noting that Medicaid does not, by federal statute, require any kind of liability insurance for *any* category of practitioner; however, one state's Medicaid Plan requires Licensed Midwives to carry liability insurance as a condition for Medicaid reimbursement.⁹¹

patients injured by malpractice bring claims and that courts and juries actually favor defendants. TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 69-73 (2005).

86. B. Sonny Bal, *An Introduction to Medical Malpractice in the United States*, 467 CLIN. ORTHOP. RELAT. RES. 339, 340 (2009).

87. *SB314 Talking Points*, ALA. MIDWIVES ALLIANCE, http://www.alabamamidwivesalliance.org/images/2012_SB314_Talking_Points.pdf (last visited Nov. 10, 2012).

88. *The Midwife Plan*, DEAN INS. AGENCY, <http://themidwifeplan.com.s123650.gridserver.com/wp-content/uploads/2011/05/Dean-Insurance-The-Midwife-Plan-and-Binding-Arbitration.pdf> (last visited Jan. 25, 2013).

89. N.Y. INS. LAW § 5502(c)(2)(D) (McKinney 2006).

90. *Id.* at 51 – 52.

91. *Washington State Orientation Manual of Licensing and Professional Practice Issues for Midwives* (Sept. 2011), MIDWIVES' ASS'N OF WASH. ST.,

One might argue that CPMs are protected from liability less by insurance coverage than by their model of practice. CPMs foster a close, honest, and open relationship between the care provider and client.⁹² This free exchange of ideas and participation by the patient in health care decision-making are both known to reduce liability.⁹³ Midwifery's conservative practice posture emphasizes physiologic birth and continuous care over the riskier multi-patient monitoring and routine interventions used in OB-attended births; thus, midwives avoid certain known iatrogenic harms and, in the process, reduce liability.⁹⁴

Nevertheless, injured patients who find themselves unable to collect damages from negligent and uninsured midwife

<http://www.washingtonmidwives.org/documents/OrientationManual-forLMs2011.pdf>.

92. *Direct-entry Midwives and Professional Liability*, ELEPHANTCIRCLE.NET, <http://elephantcircle.net/wp-content/uploads/2011/01/Liability.pdf> (last visited Jan. 24, 2013) (citing ARNOLD RELMAN, 2 ROGER J. BULGER, *MEDICAL PROFESSIONAL LIABILITY AND THE DELIVERY OF OBSTETRICAL CARE* 97 – 103 (1989)).

93. Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 *YALE L.J.* 219, 296 (1985). In fact, this is the guiding principle behind the University of Michigan Health System's successful program for minimizing medical malpractice claims. They suggest a medical system should "1. Compensate quickly and fairly when unreasonable medical care causes injury; 2. Defend medically reasonable care vigorously; [and] 3. Reduce patient injuries (and therefore claims) by learning from patients' experiences." The foundation of this scheme is the honest exchange of information.

Every patient, and, if the patient is represented, his or her lawyer, is invited to an open and honest dialogue about the issues raised in the course of his or her medical care. Open, honest, and robust discussions occur between patients and their doctors and between doctors and the lawyers poised to sue them.

Richard C. Boothman, et al., *A Better Approach to Medical Malpractice Claims? The University of Michigan Experience*, 2 *J. HEALTH & LIFE SCI. L.* 125, 139, 142 (2009).

94. Routine use of interventions such as labor induction, epidural analgesia, and C-section have been demonstrated to expose many mothers and babies to "risk of harm with marginal medical benefit or none at all." Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, (Milbank Mem'l Fund, New York, NY) Oct. 2008, at 35, *available at* <http://www.childbirthconnection.org/pdfs/evidence-based-maternity-care.pdf>. Midwives, in avoiding causing such harms, can only help in reducing their risk of malpractice liability.

providers may well feel a lack of legal recourse. This scenario is perhaps best addressed by legislative mandates that require licensed providers to disclose their liability insurance coverage status to new patients, as is the case in the Wisconsin licensure statute.⁹⁵ With appropriate informed consent procedures,⁹⁶ patients can be held to have had consented to treatment by an uninsured provider. In a sense, patients are choosing not to pay the costs of providers' liability insurance premiums up front – thus receiving care at a considerably lower price – in exchange for forgoing extensive damages in the event of negligence. Informed consent is vital to ensure that patients who take on this risk do so freely and knowingly.

The chief liability concern of hospital-based OBs interfacing with CPMs is the danger of vicarious liability for care delivered by the CPM, centering on the issue of transfers to hospitals of out-of-hospital birth patients. “Those involved in such cases—doctors and hospitals alike—may fear becoming the recipients of the blame and liability for any adverse outcomes. Accordingly, physicians and institutions may not wish to be associated with supporting home delivery because of the perceived risk of liability.”⁹⁷ Tort doctrine holds that a physician cannot be held responsible for the injuries of a patient that occurred before his duty to that patient began – that is, before she became his patient – unless the former provider was either an employee or an agent of the physician.⁹⁸ Because CPMs are not employees of OBs, there cannot be vicarious liability for actions performed in the scope of their employment,⁹⁹ nor is there an agency relationship

95. WIS. STAT. § 440.985 (2005).

96. The CPM certification includes standards for informed consent. See *Informed Consent*, NARM.org, <http://narm.org/accountability/informed-consent/> (last visited Aug. 1, 2012).

97. Ecker & Minkoff, *supra* note 34, at 1181.

98. Joseph W. Booth, *An Update on Vicarious Liability for Certified Nurse-Midwives/Certified Midwives*, 52 MIDWIFERY WOMEN'S HEALTH 153, 156 (2007).

99. Susan M. Jenkins, *The Myth of Vicarious Liability: Impact on Barriers to Nurse-Midwifery Practice*, 39 J. NURSE-MIDWIFERY 98, 101 (1994). (“[W]hen an independently practicing CNM has contracted with a physician for the latter to provide consulting or referral services, vicarious liability should not be presumed

in the absence of a contractual provision to that effect.¹⁰⁰ In fact, the more independent a CPM's practice is and the less control over her practice wielded by a collaborating OB, the safer that OB is from vicarious liability. Even if an OB and CPM worked together under a collaborative practice agreement, this agreement would merely establish protocols for consultation and transfer of the patient, rather than any direct supervisory role. Thus, the OB would not be subject to vicarious liability even in this contractual situation.¹⁰¹

Regardless of the scant legal basis for an OB to be held vicariously liable for CPM practice, from a practical standpoint, OBs might feel the question of causation to be sufficiently difficult to the point that it could render a jury unable to distinguish injury caused by an OB from that caused by a CPM, and both of those together from an injury that was not caused by either provider. For this reason, some states have included specific language in CPM licensing statutes exempting physicians from such liability.¹⁰² States might find more security in legislating if the intention to include CPMs in state-recognized medical providers were indicated by federal legislation.¹⁰³

to exist for the simple reason that control cannot be found or implied."). Although the author was speaking of CNMs, her analysis could be equally well applied to CPMs.

100. Booth, *supra* note 98, at 157.

101. *Id.* at 156 ("A review of the case law found no reported cases that would support a theory of vicarious liability by virtue of a collaborative practice agreement being in effect.").

102. *See, e.g.*, WIS. STAT. § 440.988 (2005) ("No health care provider shall be liable for an injury resulting from an act or omission by a licensed midwife, even if the health care provider has consulted with or accepted a referral from the licensed midwife.").

103. Furthermore, one might wish that the legislative culture, in general, were more receptive to supporting injured patients regardless of the childbirth attendant's negligence or lack thereof, while also effectively curtailing the practice of negligent providers. Discussion of such provisions is, unfortunately, beyond the scope of this article.

FEDERAL LEGISLATION

One such recent bill was the Access to Certified Professional Midwives Act, introduced in March 2011. It aimed to “amend title XIX of the Social Security Act to provide access to certified professional midwives for women enrolled in the Medicaid program.”¹⁰⁴ The Act would have expanded Medicaid coverage of CPMs beyond those who merely operate birth centers,¹⁰⁵ to include *all* CPMs. Although the legislation failed to progress, this proposed integration of CPMs into federal and state government infrastructure bodes well for collaborative efforts in general, and may have implications for broader health insurance reform movements and future coverage of CPM services by private health insurance. An example is Vermont’s recent decision to require private health insurers to cover the services of midwives who attend home births.¹⁰⁶ An even broader piece of legislation was the Maximizing Optimal Maternity Services (MOMS) for the 21st Century Act.¹⁰⁷ The Act was introduced in June 2011 to “promote optimal maternity outcomes by making evidence-based maternity care a national priority”¹⁰⁸ through research and education support, to promote births attended by CPMs and in out-of-hospital settings.¹⁰⁹

104. Access to Certified Professional Midwives Act of 2011, H.R. 1054, 112th Cong. (2011).

105. See discussion *supra* **CNM-CPM CONVERGENCE – ACA BIRTH CENTER COVERAGE**.

106. Lisa Rathke, *Vermont Requires Insurers to Cover Home Births*, ASSOCIATED PRESS (May 19, 2011, 12:37 PM), available at http://www.boston.com/news/local/vermont/articles/2011/05/19/vt_insurers_must_c_over_home_births/?camp=pm. Close on the heels of this decision came Vermont's landmark introduction of single payer health insurance. *Vermont Poised to Become 1st State to Enact Single-Payer Healthcare* (Democracy Now! Broadcast May 26, 2011), available at <http://www.democracynow.org/2011/5/26/stream>. See also Dave Gram, *Vermont Governor Hails Health Ruling, Pushes Bigger Plan*, ASSOCIATED PRESS (June 28, 2012, 6:53 PM), available at <http://www.sfgate.com/news/article/Vt-gov-hails-health-ruling-pushes-bigger-plan-3671616.php>.

107. MOMS for the 21st Century Act, H.R. 2141, 112th Cong. (2011).

108. H.R. 2141, 112th Cong. (2011).

109. H.R. 2141, 112th Cong. (2011).

Legislative provisions to accept CPMs into the larger health system, together with a deeper understanding of medical malpractice liability and liability insurance, may make it possible to integrate CPMs into the same general system that supports OBs, while also allowing CPMs to maintain their autonomous practice. To examine such integrated practice in action, one can look to Wisconsin or the Netherlands.¹¹⁰

CASE STUDY: WISCONSIN

Wisconsin enacted CPM licensure in 2006, allowing CPMs legal status as Licensed Midwives (LMs).¹¹¹ The title LM is protected, and a license is required to practice midwifery; a cross-reference reaffirms the CNM credential as well.¹¹² Rule making is tied to standards established by the National Association of Certified Professional Midwives (NACPM).¹¹³ The statute explicitly forbids rules that require LMs to possess nursing degrees or practice midwifery under the supervision of another health care provider.¹¹⁴ Provision is made for rules to include the use of certain medications; however, permission to use forceps or vacuum extraction may *not* be included in the rules.¹¹⁵ No section of the licensing code requires LMs to carry malpractice liability insurance. However, the Informed Consent section specifies that clients must be told what, if any, coverage the LM carries.¹¹⁶ LMs are governed by an advisory committee

110. In fact,

[l]essons learned in the study of a small slice of one health system in its social and cultural context can show us how health systems are built. When our analysis of birth in the Netherlands is complete, we will have a firm grasp on the way social structures – political, professional, educational, scientific, governmental, corporate, and medical – shape the way health care is delivered.

RAYMOND G. DE VRIES, *A PLEASING BIRTH: MIDWIVES AND MATERNITY CARE IN THE NETHERLANDS* 13 (2004).

111. WIS. STAT. § 440.9805 note (2005).

112. *See* WIS. STAT. §§ 440.981 – 82 (2005).

113. WIS. STAT. § 440.984(1) (2005).

114. WIS. STAT. § 440.984(4) (2005).

115. WIS. STAT. § 440.984(4)(e) (2005).

116. WIS. STAT. § 440.985 (2005).

made up of three midwives (two LMs and one CNM), one physician, and one out-of-hospital midwifery care client.¹¹⁷ Finally, the code specifically exempts health care providers from vicarious liability “for an injury resulting from an act or omission by a licensed midwife”,¹¹⁸ and goes on to underline that this is the case regardless of any consultations or referrals that have taken place.¹¹⁹

The rules themselves specify the LM’s responsibilities during the prenatal, intrapartum, and postpartum periods.¹²⁰ In many cases, LMs are required to *offer* certain components of standard hospital births, such as prenatal testing, newborn screening and eye prophylaxis.¹²¹ The rules command that a midwife consult with a physician or CNM when a pregnancy displays “significant deviations,”¹²² but notes that “[c]onsultation does not preclude the possibility of an out-of-hospital birth.”¹²³ Conditions for transfer are included,¹²⁴ as are the few circumstances in which an LM may *not* accept a patient (e.g. when a client suffers from active tuberculosis or has experienced a previous C-section with vertical incision).¹²⁵

Both rules and statutes give the impression of an independent, self-regulating health profession, bound by a responsibility to its clients to operate under a model of informed consent. Throughout the code, CNMs have the opportunity to transform their legal status to that of a LM, based on their certification by the American College of Nurse Midwives. This allows CNMs to become CPMs (LMs) in order to practice independently without requiring physicians to discard supervision requirements for continuing CNMs. An alliance

117. WIS. STAT. § 440.987 (2005).

118. WIS. STAT. § 440.988 (2005).

119. WIS. STAT. § 440.988 (2005).

120. WIS. ADMIN. CODE SPS § 182.03(1) (2007).

121. WIS. ADMIN. CODE SPS § 182.03(1) (2007).

122. WIS. ADMIN. CODE SPS § 182.03(4)(a) (2007).

123. WIS. ADMIN. CODE SPS § 182.03(4)(a) note (2007).

124. WIS. ADMIN. CODE SPS § 182.03(5)(a) (2007).

125. WIS. ADMIN. CODE SPS § 182.03(4)(b) (2007).

between CNMs and LMs is thus made possible because CNMs are included in the opportunities presented to LMs – opportunities that CNMs may have long sought. The environment, in turn, provides more accountable provider options to patients.

CASE STUDY: THE NETHERLANDS

Though Wisconsin's regulatory scheme is progressive in the United States, a superior model of the CPM-OB relationship is evident in the Netherlands whose long, uninterrupted history of home birth has allowed it to construct a flexible, integrated model of childbirth care with provisions for OBs, family doctors (*huisarten*), midwives (*vroedvrouwen*¹²⁶), hospitals, and homes, resulting in over twenty-three percent of the nation's births taking place at home.¹²⁷ This system is successful with respect to more than place and attendance of birth, which can be demonstrated by its excellent outcomes.¹²⁸ The system's key elements are licensure equivalency for all providers, robust protocols for risk assessment and continuum of care, power-sharing by childbirth providers in both the medical and political

126. *Vroedvrouw*, the Dutch term for midwife, is used here in order to distinguish Dutch midwives from American midwives, reflecting the *vroedvrouw's* distinctive training and status within a very different medico-legal system.

127. Raymond G. de Vries & Simone E. Buitendijk, *Science, Safety and Place of Birth – Lessons from the Netherlands*, 7 (Suppl. 1) *Eur. Obstetrics & Gynaecology* 13, 14 (2012) (citing CBS Statline, *Centraal Bureau voor de Statistiek* (2012), available at <http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLNL&PA=37302&D1=0-2,23-44&D2=a&HD=120104-2121&HDR=T&STB=G1> (last modified Dec. 2, 2011)).

128. In 2005, the Dutch perinatal mortality rate was 4.7 per 1,000 births, while the U.S. rate was 6.9. PowerPoint: Marian MacDorman & T.J. Mathews, Presentation, *Behind International Rankings of Infant Mortality: How the United States Compares with Europe* at the National Conference on Health Statistics, slide 4 (Aug. 16 – 18, 2010), available at <http://www.cdc.gov/nchs/data/databriefs/db23.pdf>. Additionally, the World Health Organization maintains that an ideal C-section rate is 5 – 15%. World Health Org., *Appropriate Technology for Birth*, 2 *THE LANCET* 436, 437 (1985). While the U.S. rate in 2007 was 32%, the Dutch rate was 12%. Denise Grady, *Caesarean Births Are At a High in U.S.*, *N.Y. Times*, Mar. 24, 2010, at A13; Emily Sciarillo, *Dataset of the Day: Birth in the USA*, *GEOIQ BLOG* (Apr. 22, 2009), <http://blog.fortiusone.com/2009/04/22/birth-in-the-usa/>.

arenas, and an ongoing national policy discussion on the subject of childbirth.¹²⁹

The Dutch regulation of the medical profession is one of obligatory registration rather than licensure. OBs, *huisarten*, and *vroedvrouwen* are all autonomous, professional participants in a centralized, heavily regulated obstetrical system.¹³⁰ Licensure has been seen as unnecessary due to *vroedvrouwen* training in government-run midwifery schools, which confer the equivalent of uniform certification after what is, essentially, vocational training.¹³¹

Risk assessment is achieved by assigning pregnant women to a flexible risk category, as determined by a formal set of health criteria. Low-risk patients may give birth either at home with a *vroedvrouw* or in a clinic with a *huisarts*, while high-risk patients at the onset of labor give birth in a hospital under an OB's care.¹³² These categories allow for changes in condition in both directions; it is not uncommon for a *vroedvrouw* or *huisarts* to declare a patient to be removed from low risk and refer the patient to a high-risk OB to resolve medical issues, and then have the OB return the patient to low-risk for a home birth.¹³³ These handoffs are both the result and the continuing source of the system's cohesive nature.¹³⁴

Dutch OBs are favored with a collegial rather than a supervisory relationship with *vroedvrouwen*. Dutch physicians, as a group, never achieved the cultural and economic power

129. See DE VRIES, *supra* note 110, at 7 – 8, 30, 50 – 51, 57 – 59, 69 – 74, 170 – 73.

130. See *id.* at 51 – 59.

131. However, because of a recent greater influx of medical professionals due to the unification of Europe, Dutch officials are considering instituting a licensing scheme. C. P. M. van der Vleuten, *National, European Licensing Examinations or None at All?*, 31 MED. TCHR. 189, 189 (2009).

132. See DE VRIES, *supra* note 110, at 30.

133. See *id.*

134. It is true that the context of this unification is the Dutch national health insurance system, which has no U.S. equivalent. However, given the public/private model of the Dutch system, similar in that respect to the American model and the health insurance reforms well underway in the United States, it is not unreasonable that the two systems might at some point begin to converge.

within health systems and the political arena that their counterparts did in the United States, therefore, *vroedvrouwen* need not worry about their interests being overshadowed or eclipsed by OBs.¹³⁵

Finally, the element of the Dutch system perhaps most responsible for supporting a cooperative model is its insistence on incremental reform in both law and health policy, and the characterization of the health care system as engaging in continuous debate about its structure and reform.¹³⁶ Through agreement on the importance of safe, accessible, and affordable birth options as a goal, the Dutch achieve what Americans can only dream.

CONCLUSION

This article has examined the four relationships in which Michigan OBs and CPMs might find themselves following the state's adoption of a CPM licensure bill. *Exclusion* is undesirable because it effectively prevents the practice of direct entry midwifery of any kind. *Coexistence*, the current Michigan relationship, is only marginally better. Although it features no affirmative prohibitions against CPM's practice, it allows CPMs enough latitude to practice only until a bad outcome results in civil and criminal sanctions. *Subordination* is exemplified by Michigan's CNMs. It is the path to avoid for an OB-CPM relationship because, although CNMs practice safely within the medical system, their ability to do so as autonomous professionals is undercut by the need for physician supervision. *Cooperation* is the desirable goal for a post-licensure relationship, because it provides for integrated practice between OBs and CPMs, yet allows CPMs to remain autonomous professionals.

Women desire and deserve childbirth attendants who are accessible, affordable, and safe, and whose care provides for best

135. DE VRIES, *supra* note 110, at 101 – 02.

136. André den Exter et al., *Health Care Systems in Transition: Netherlands*, EUR. OBSERVATORY ON HEALTH SYSTEMS & POLICIES 1, 133 (2005).

outcomes for both mother and baby. CPMs attend low-risk women most effectively when OB backup is readily available for patients who require more specialized care, while also allowing CPMs and OBs to reach across the gap between obstetrics and midwifery without fear of malpractice liability, disciplinary action, or criminal prosecution. Models exist in other states and countries to show how these goals can be accomplished. Once Michigan enacts CPM licensure, the two caring professions will be free to take their first steps together toward their common goals.