APPENDIX I

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I. Background

Since Ms. Webster's appeal requires this Court to construe not only Delaware's midwifery practice law and rules, *see* 16 *Del. C.* § 122(3)(h); 16 *Del. Admin. C.* § 4106 (2002), but also its medical practice act, 24 *Del. C.* § 1701 *et seq.,* the social and legislative history that recounts the rise of medical licensure laws cannot be ignored. The Delaware Medical Practice Act reads, in part:

> (c) Offering or undertaking to prevent or to diagnose, correct, and/or treat in *any manner* or *by any means, methods, or devices* a disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of another person, *including the management of pregnancy and parturition*; . . . 24 *Del. C.* § 1702(9)(c).

Construction of this law requires the Court to consider the historical context in which such overly-broad statutes were enacted in the late nineteenth and early twentieth century, as well as the significance of newer midwifery practice laws, such as Delaware's, which recognize and provide for the inevitable overlap of the physician and midwife scopes of practice. The context tells us that the quoted language cannot be read as exclusive if we are to give proper effect to either statute.

This background section considers (1) the historical context of midwifery and midwives in the United States; (2) the historical context of medical practice laws; (3) the near-eradication of U.S. midwifery in the mid-

twentieth century; (4) the revival of U.S. direct entry midwifery; and (5) the subsequent rise of midwifery licensing laws that ultimately preserve the right of midwives to engage in those aspects of midwifery scope of practice that appear to overlap that of medicine. We ask the court to consider this context with regard to Ms. Webster (also referred to herein as the Appellant) and hope it will help the court to interpret the regulatory scheme enacted by Delaware to account for the overlap in scopes between midwifery and medicine.

A. Origins and History of Midwifery

"Midwife," a word rooted in old English, literally means "with woman." Sheila Kitzinger, *Rediscovering Birth* 131 (2000) [hereinafter Kitzinger]. The first recorded usage of "midwife" dates back to 1303. *See* Judith Pence Rooks, *Midwifery & Childbirth in America* 3 (1997) [hereinafter Rooks, *Midwifery*]. Thus midwifery is often described as one of the oldest professions, with midwives mentioned both in the writings of Hippocrates and the Bible. *Id.* at 12. During the Middle Ages, midwives were recognized as skilled birth attendants with a valuable understanding of the physiological processes of pregnancy and childbirth. Kitzinger, *supra*, at 132. Midwives learned from direct experience in caring for pregnant and laboring women. *Id.* at 133. While midwives experienced great favor in

Europe during this time period, they faced denouncement as witches during the late Middle Ages. *Id.*

In the New World, idwives provided care and support to the majority of pregnant women for nearly 250 years. Rooks, *Midwifery*, *supra*, at 17-18. Like the midwives of the Middle Ages who learned their trade by providing care to pregnant women, early Modern Era midwives in North America gained experience by sharing skills and attending births alongside more experienced midwives. Kitzinger, *supra*, at 134.

At the beginning of the 20th century, midwives provided care for the majority of pregnant, laboring, and postpartum women in the United States. *See* Robbie Davis-Floyd & Christine Barbara Johnson, *Mainstreaming Midwives: The Politics of Change* 32-44 (2006) [hereinafter Davis-Floyd]. In 1923, an estimated 60,000 midwives practiced in the United States – a figure that researchers estimate to be nearly double the number of obstetricians in the United States today. Jennifer Block, *Pushed: The Painful Truth About Childbirth and Modern Maternity Care* 213 (2007). During this time period, midwives particularly served lower-income women and/or women of color, who medical researchers considered "teaching material." Barbara Ehrenreich & Deidre English, *Witches, Midwives, and Nurses: A History of Women Healers* 38 (2d ed., 2010) [hereinafter Ehrenreich].

As physicians gained prominence and political power in the 19th and 20th centuries, they encouraged local governments to create laws banning the practice of midwifery. Davis-Floyd, *supra*, at 32. As a result, midwives faced difficulties in legally practicing their trade because licensing laws served to legitimize only university-trained physicians. Ehrenreich, *supra*, at 53. Additionally, the majority of 19th century midwives were recent European immigrants and African-American women, and efforts to discredit their skills were rooted in racism. Kitzinger, *supra*, at 136. In an effort to discourage women from seeking the services of midwives, physicians and obstetricians engaged in effective smear tactics, referring to midwives as unskilled, unhygienic, and incapable care providers. Ehrenreich, *supra*, at 85.

Efforts to discredit midwives were based in sexism as well. Kitzinger, *supra*, at 136. Physicians regularly regarded midwives as unfit to attend births based solely on the fact that midwives were women. *Id.* at 132 (citing Richard W. Wertz & Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* 97 (1979) ("Periodical infirmity of their sex . . . in every case . . . unfits them for any responsible effort of mind.") These tactics were effective. By the middle of the 20th century, physicians had prevailed: the vast majority of women gave birth in hospitals under the care of physicians and obstetricians. *Id.*

Despite their promises of safer and more competent maternity care, physicians were unable to lower the rates of childbirth-related deaths. In fact, in the years following statewide bans on midwifery, infant and maternal mortality rates rose. Ehrenreich, *supra*, at 86. In Massachusetts, for example, midwifery became illegal in 1907. Kitzinger, *supra*, at 137. Between 1918 and 1925, birth injury-related infant deaths rose 44%. *Id.* Additionally, women who gave birth in hospitals were more likely to die during and after childbirth than women who gave birth at home. *Id.* at 136. These maternal deaths were largely caused by the spread of puerperal fever because doctors examined pregnant and laboring women without washing their hands. *Id.* Nevertheless, medical texts largely attributed puerperal fever to Black and immigrant midwives who attended the births of poor women and/or women of color. Katy Dawley, *The Campaign to Eliminate the Midwife*, 100 Am. J. Nursing 50-56 (2000). Thus, as obstetricians gained prominence in urban areas, midwives were excluded from practicing, and childbearing women suffered the consequences. Kitzinger, *supra*, at 136.

Though midwives were excluded from practicing in urbanized areas that hosted hospitals, African-American midwives, colloquially referred to as "granny midwives" and later as "grand midwives," continued to provide care to African-American, southern, and rural white women. Kitzinger,

supra, at 134, 137. During this time period, African-American midwives reported better outcomes than their physician counterparts. *Id.* at 137. In Alabama during the early 1940s, for example, maternal mortality rates for white women receiving care from doctors in hospitals were 9% higher than women receiving care from African-American midwives. *Id.* Additionally, the rate of neonatal mortality for white infants was more than 20% higher than the Black infants who were cared for by African-American midwives. *Id.* Nevertheless, midwives were increasingly denigrated, and in particular, immigrant and African-American midwives were largely forced out of practice. Christa Craven, *Pushing for Midwives* 11 (2010) [hereinafter Craven]. By the end of the 1950s, midwives in North America were almost entirely excluded from attending births in the United States. Davis-Floyd, *supra*, at 4. Thus, lower-income women, women of color, and those unable to access care within hospitals were left unable to access prenatal care. Craven, *supra*, at 8.

B. Development and Enactment of Medical Practice Laws

Efforts by organized medicine to discredit and suppress its midwife competition went beyond the above-described disinformation campaign. Beginning in the 19th century, physicians lobbied state legislatures for all-encompassing "medical practice" laws, some of which incorporated

maternity care within the definition of "medicine." Davis-Floyd, *supra*, at 32. Rooks describes this campaign and the laws that resulted:

> Physicians encouraged the passage of laws that required licensure, allowing them to control access to the profession and prevent others from practicing medicine. The definitions of medical practice built into these laws were extremely broad and usually included a provision that made it illegal for anyone not licensed as a physician to carry out any acts included in the definition. Rooks, *Midwifery*, *supra*, at 21 (citing Barbara Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 Yale J. on Reg. 417 (1982) (hereinafter, Safriet, *Health Care Dollars*).

By a remarkable legislative sleight of hand, these laws expanded the scope of care that doctors could legally provide, while simultaneously classifying the partially-overlapping scopes of practice of midwives and other as-yet unlicensed practitioners as the unauthorized practice of medicine. *See, generally,* Davis-Floyd, *supra*, at 32-33; *see also,* Ehrenreich, *supra*, at 85-86. The laws that resulted were written in language intended to encompass the entire range of health care services. Safriet, who has written extensively on scope of practice regulatory issues, describes the process:

> Across the country, physicians (also known as medical doctors or "MDs") were the first health care providers to secure licensure. By the early 1900s, so-called "medical practice acts" had been adopted in each state, and being first on the scene, physicians, perhaps understandably, swept the entire human condition within their purview. In almost every state, their legislatively-recognized scope of practice gave them exclusive domain over "the practice of medicine." Barbara Safriet, *Closing the Gap Between Can and May in Health Care Providers' Scopes of Practice: A Primer for Policymakers,* 19 Yale J. on Reg. 301, 306 (2002) [hereinafter Safriet, *Closing the Gap*] [citing, generally Paul Starr, *The Social Transformation of*

> *American Medicine*, 102-12 (1982) (hereinafter Starr) ("an excellent description of the evolution of organized medicine's licensure activities")].

According to Starr, this transformation was motivated partly by financial considerations and partly a desire for prestige, rather than safety or quality of care. The campaign for medical hegemony was not

> propelled solely by the advance of science and the satisfaction of human needs. The history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict over the emergence of new hierarchies of power and authority, new markets, and new conditions of belief and experience. Starr, *supra*, at 4.

In most states, organized medicine secured a legislative scope of practice so "comprehensively defined in law, almost any activity directed at 'health or sickness'– especially if done for compensation – was deemed the practice of medicine. Such laws essentially gave "licensed physicians . . . 'the exclusive right to practice" and "exclusive domain over "the practice of medicine." Safriet, *Closing the Gap*, *supra*, at 306-07.

With such laws functioning as the cornerstone of health care professional licensing, other providers in turn found themselves obliged to secure legislative recognition and authorization to demarcate their own scopes of practice, *which would nearly always necessarily overlap with some aspect of medicine's overly-broad scope*. But in the early twentieth century, American midwives were not only unprepared to take on organized

medicine, but were also socially, politically, and economically unable to fight back. Rooks points out that in the early twentieth century, "[t]here was no parallel effort to license and improve the education of midwives" who

> were poorly situated to counter the campaign against them. They were women. Relatively few had formal midwifery training, and those that did were immigrants, many of whom could not speak and write English fluently . . ., mainly poor, and many were black. . . . As female members of the least powerful segments of American society, midwives lacked the role models, access, experience, and resources needed to influence the institutions that wield power,

such as state legislatures and public health departments. Rooks, *Midwifery*, *supra*, at 24. In *Mainstreaming Midwives: The Politics of Change*, Davis-Floyd and Johnson make the related point that American midwives of that era, unlike their European counterparts who were able to secure their scope of practice by law at the time, lacked political, cultural, and socioeconomic cohesiveness and power, and were unable to organize into professional organizations for lobbying purposes. "Impediments to organization, included legal and cultural prohibitions against women regarding public speaking, leadership, finances." Davis-Floyd, *supra*, at 32-33.

Whether composed of immigrants serving urban ethnic enclaves, or African-American women in the rural south, such groups were singularly unempowered to win legislative battles against groups of educated white men, who added claims of scientific superiority to their existing political,

socioeconomic, and cultural advantages. The initial result, according to Ehrenreich and English, was widespread medical monopoly underwritten by the state legislatures. Ehrenreich, *supra*, at 85. "In state after state, new tough physician licensing laws sealed the doctor's monopoly on medical practice. All that was left was to drive out the last holdouts of the old people's medicine – the midwives." *Id*. Once this sweeping authority was in place, organized medicine and state public health departments turned their attention to eradicating midwives – or at least controlling them and minimizing their role.

C. The History and Revival of Direct Entry Midwifery in the United States

In the 1930s, women began writing letters to *Ladies Home Journal* and *Redbook,* detailing the impersonal care they received in hospitals during pregnancy and childbirth. Davis-Floyd, *supra*, at 38. They recounted stories of being strapped down, medicated, separated from their husbands, and left largely unattended by hospital staff. *Id.* ("[Women] were often left alone to scream until the baby finally came; many women were subsequently haunted by spotty nightmarish memories [due to scopolamine, a "psychedelic amnesiac"]."")

Published studies of midwifery care from the early 20th century tend to show better outcomes for midwives than for physicians and medical students of the time. Rooks discusses a 1932 study by the Pennsylvania Division of Children's Hygiene reporting on nearly 50,000 midwife deliveries between 1921 and 1931. Rooks, *Midwifery*, *supra*, at 28. "The maternal mortality ratio for the midwives' clients was 1.8 per thousand births, compared with a statewide ratio of 6.6 per thousand." *Id.* A contemporary New York City study demonstrated a maternal "mortality rate of 1.6 per 1,000 live births compared with 4.5 per 1,000 for women attended by physicians." *Id.* at 29. Researchers who presented at the 1925 White House Conference on Child Health and Protection found no increased incidence of midwife-related maternal mortality in any of 29 state studies. *Id.* Any higher neonatal mortality rates were found to relate to the relative poverty of the midwives' clients rather than to any fault of the midwives themselves. *See id.* at 28-29; *see also* Neal Devitt, *The Statistical Case for Elimination of the Midwife: Fact Versus Prejudice, 1890-1935 (Parts 1 and 2)*, 4 Women & Health 81-96, 169-183 (1979) [hereinafter Devitt]. Devitt's two-part historical article is "considered one of the most seminal pieces on the subject," because it

> deconstructs for the first time the myth that traditional midwives had inherently worse outcomes than physicians. His statistical analysis of

> research from primary sources shows that women attended by midwives had significantly lower maternal and neonatal mortality rates than did those women attended at home by physicians. Zeina Omisola Jones, *Review Essay: Knowledge Systems in Conflict: The Regulation of African- American Midwifery*, 12 Nursing Hist. Rev. 167-84 (2004) (citing Devitt).

Despite these positive studies, most states allowed midwifery registration and licensing to fade away by attrition, as the number of midwives and of births they attended likewise declined, during the first half of the 20th century. "The proportion of U.S. births attended by midwives declined from about 50 per cent in 1900 to 12.5 percent in 1935. By 1932, 80% of all midwives practicing in the United States were . . . in the rural south." Rooks, *Midwifery*, *supra*, at 30.

Several decades later, as women and healthcare consumers became increasingly disenchanted with the options available to them in hospitals and with this over-medicalization of birth in particular, women began organizing in order to expand childbirth options for pregnant women and their families. Davis-Floyd, *supra*, at 38-39. Some organized to change hospital policies and otherwise implement friendlier practices in maternity care. *Id.* at 38; Craven, *supra*, at 51. Others, however, searched for midwives in the hope of locating more respectful maternity care and out-of-hospital birth options. Craven, *supra*, at 51. Researchers have remarked on the "strange bedfellows" that united to advance midwifery and increase options for

natural childbirth during this time period. *Id.* at 49 (noting that "feminists, members of the religious right, 'back-to-the-earth' types, pro-family crusaders, peace activists, and libertarians" joined together to increase access to natural childbirth options and midwifery care.)

Driven by the demand for more humanized care during pregnancy and childbirth, midwifery experienced a renaissance during the 1960s and 70s. *Id.* at 4, 50. This revival was inspired and informed by the natural childbirth, counterculture, and feminist movements of the same time period. Davis-Floyd, *supra*, at 38, 40. These midwives would later be called "lay midwives" or "direct-entry midwives". Kitzinger, *supra*, at 130 (distinguishing lay midwives, whose skills are built from apprenticeship and direct experience, from direct-entry midwives, whose skills are built from "academic learning, empirical skills from apprenticeship" and experience attending births). In recent years, direct-entry midwives have been referred to as "non-nurse midwives," a misnomer that results in a serious misimpression of midwifery and its relationship to nursing. In most countries,particularly in continental Europe, the majority of midwives are direct-entry midwives. *See* Judith P. Rooks, *Professional Issues in Midwifery* 3 (Lynette A. Ament, eds., 2006) (hereinafter Rooks, *Professional*). However, the history and dichotomous aspect of midwifery in

the United States has led to the impression that direct-entry midwives are somehow less qualified than nurse-midwives. *Id.*

During the 1970s, groups of new midwives emerged across the United States, with the most notable groups in California, Washington, Texas, Tennessee, and Massachusetts. Davis-Floyd, *supra*, at 40. These midwives developed skills by attending births and sharing their experiences with other midwives. *Id.* They also collaborated with physicians to increase their knowledge, emergency training, and skills. In 1977, the first national gathering of lay midwives occurred in El Paso, Texas, at a conference called the First International Conference of Practicing Midwives. *Id.* at 41.

An increasing number of women and their families began to lose faith in the medicalized approach implemented in hospitals and consequently decided to give birth at home with midwives. *Id.* at 39. Unsurprisingly, rates of births occurring at home more than doubled between 1970 and 1977. *Id.* (noting that the rates of home birth rose from .6% in 1970 to 1.5% in 1977). Throughout the 1980s midwives continued to educate themselves, train other midwives, and develop a unique body of knowledge about the physiological processes of birth as it occurred outside the hospital. *Id.* at 43.

D. Initial Attempts at State Regulation of Midwives

By the time midwifery experienced its revival as modern direct-entry midwifery in the 1960s and 1970s, and the movement toward licensure began to take hold in the late 1980s, few of the older traditional licensed, permitted, or registered midwives remained, with most of the programs either shut down or fallen into dormancy. Along with the development of professional societies, certification, accreditation, and a nationally-recognized scope of practice, the trend in recent decades toward state scope of practice recognition through licensure is an important part of the modern professionalization of direct-entry midwives as Certified Professional Midwives (CPMs). *See* Davis-Floyd, *supra*, at 7.

Although few states provided for licensure of midwives in the early 20th century, many states chose to not ban midwifery outright. In part because state public health officials recognized that midwives were still needed, if only to serve poor women, and in part because contemporary studies comparing midwifery care with maternity services provided by physicians consistently reported good midwife outcomes, the majority of states developed laws and public health rules to regulate midwives. "By 1930, all but ten states required midwives to register. . . . In addition to

registration, the main intent of most of the laws was to require midwives to conform to certain public health practices." Rooks, *Midwifery*, *supra*, at 28.

In language typical of such statutes, paragraph (3)(h) of Delaware's midwifery law grants authority to what is now the Department of Health and Social Services ("DHSS") to "[c]ontrol the practice of non-nurse midwives including the issuance of permits and protect and promote the health of all mothers and children[.]" 16 *Del. C.* § 122(3)(h). DHSS's rules, unlike a mere registration statute, provide for licensing (in the form of a permit), a comprehensive midwifery scope of practice, and a prohibition against the unauthorized practice of midwifery. 16 *Del. Admin. C.* § 4106 (2002).

II. Contemporary Direct-Entry Midwifery, as Practiced by Certified Professional Midwives, Has Become Established in the United States as a Distinct Licensed and Regulated Health Care Profession.

At the present time, CPMs like Ms. Webster are able to practice legally in most states, either through legislation, judicial interpretation, and/or the written opinion of state Attorneys General. The Big Push for Midwives, *Big Push for Midwives State Regulation PushChart* (May 17, 2013), http://pushformidwives.org/wp-content/uploads/2013/05/Push-for-Midwives-State-Regulation-PushChart_MAY-2013.pdf [hereinafter *PushChart*]. In 26 states including Delaware, the practice of midwifery is recognized and regulated in statutes and implementing rules as a health

profession distinct from medicine. *See Alaska Stat.* § 08.65.050 (2010); *Ariz. Rev. Stat. Ann.* §§ 36-751 to -759 (West 2010); *Ark. Code Ann.* §§ 17-85-102 to -107 (West 2010); *Cal. Bus. & Prof. Code* §§ 25052521 (West 2010) (amended by *Assemb. B.* 1308 (West 2013)); *Colo. Rev. Stat.* §§ 12-37-101 to -110 (2010); 16 *Del. C.* § 122(3)(h) (2010); *Fla. Stat. Ann.* §§ 467.001 to -.207 (West 2010); *Idaho Code Ann.* §§ 54-5501 to 5513 (2010); *La. Rev. Stat. Ann.* §§ 37:3240-:3242 (West 2010); *Minn. Stat. Ann.* §§ 147D.01 to -.27 (West 2010); *Mont. Code Ann.* §§ 37-27-101 to -325 (2010); *N.H. Rev. Stat. Ann.* §§ 326-D:1-:14 (2010); *N.J. Stat. Ann.* §§ 45:10-1 to-3, 13:35-2A.2 (West 2010); *N.M. Stat. Ann.* §§ 61-6-17, 24-1-3 (2010); *N.Y. Educ. Law* §§ 6950-6958 (McKinney 2010); *Or. Rev. Stat.* §§ 687.405 to -.495 (2010); *S.C. Code Ann.* §§ 44-89-30 to -100 (2010);
Tenn. Code Ann. §§ 63-29-101 to -116 (2010); *Tex. Code Ann. Occ.* Ch. 203 (West 2010); *Utah Code Ann*. §§ 58-77-101 to -603 (West 2010); 26 *Vt. Stat. Ann.* §§ 4181-91 (West 2010); *Va. Code Ann.* §§ 54.1-2957.7 to -2957.13 (2010); *Wash. Rev. Code Ann.* §§ 18.50.010 to -.900; *Wis. Stat. Ann.* §§ 440.9805-.9888 (West 2010); *Wyo. Stat. Ann.* §§ 33-46-101 to -107 (2010). These statutes and/or regulations are typically characterized by such significant hallmarks as a definition of the licensed scope of practice; a prohibition of unlicensed (or unpermitted) practice as the "unauthorized

practice of *midwifery*," and the assignment of rulemaking authority to a state agency or board to implement the statute. In two additional states, the practice of midwifery by CPMs is authorized by statute but is not specifically licensed. In yet other states, the practice of midwifery has been ruled a legal practice distinct from the practice of medicine or nursing, either by judicial or administrative decision, and/or by the formal opinion of the state Attorney General. The judicial decisions in many of these states will be discussed in Argument Section I.B of this Brief, under the heading Midwifery Is Not the Practice of Medicine.

A. Certified Professional Midwives: Specialized Practitioners in Out-of-Hospital Maternity Care

Certified Professional Midwives are midwives who specialize, by education and experience, in out-of-hospital birth and maternity care. According to the North American Registry of Midwives (NARM), one of the *amici* submitting this Brief and the certification and credentialing body for Direct-entry Midwives, the "Certified Professional Midwife (CPM) is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by NARM and is qualified to provide the Midwives Model of Care." Midwives Alliance of North America, *What is a Midwife?*, http://mana.org/about-midwives/what-is-a-

midwife. The CPM is the only U.S. midwifery credential that requires knowledge about and experience in out-of-hospital settings.

Most CPMs deliver care in private homes or freestanding birth centers throughout the United States, Canada, and Mexico. Providing continuous care for women throughout their childbearing cycle, CPMs generally carry a relatively low client load, which allows for more personalized and comprehensive care than typical obstetrical practices. The scope of practice of the CPM is derived from the North American Registry of Midwives (NARM") Job Analysis, state laws and regulations, and individual practice guidelines developed by each midwife according to her skills and knowledge. CPMs are credentialed – that is, "certified" – by NARM to provide out-of-hospital maternity care for healthy women experiencing normal pregnancies. The CPM credential issued by NARM is nationally accredited by the National Commission for Certifying Agencies (NCCA), which is the accrediting arm of the Institute for Credentialing Excellence ("ICE"). The NCCA accredits more than 200 professional credentials, such as nurse-midwives, nurse anesthetists, nurse practitioners, and critical care nurses. *See* Institute for Credentialing Excellence, *ICE: External Home Page*, http://www.credentialingexcellence.org.

Based upon a set of Core Competencies developed by the Midwives Alliance of North America (MANA), another of the *amici* submitting this Brief, the guiding principles of CPM practice are to work with women to promote healthy pregnancies and to provide education to help them make informed decisions about their own care. *See* Midwives Alliance of North America, *Core Competencies for Basic Midwifery Practice* (Aug. 4, 2011), http://mana.org/pdfs/MANACoreCompetenciesColor.pdf. In partnership with their clients, CPMs carefully monitor the progress of pregnancy, labor, birth, and postpartum period and recommend appropriate management if complications arise, collaborating with other healthcare providers when necessary. *Id.* at 2. The key elements of this education, monitoring, and decision making process are based on evidenced-based practice and informed consent. *Id.* at 3, 5.

CPMs practice as autonomous health professionals working within a network of relationships with other maternity care providers who can provide consultation and collaboration when needed. *Id.* at 2. All CPMs meet the standards for certification set by the NARM. North American Registry of Midwives, *NARM - What is a CPM?*, http://narm.org. In the United States, CPMs provide unique and critical access to normal physiologic birth, *id.*, which profoundly benefits mothers and newborns as

discussed below. Although qualified to practice in any setting, they have particular expertise in providing care in homes and free-standing birth centers, and own or work in over half of the birth centers in the United States today. *Id.*

The NARM website explains that its CPM certification is a rigorous educational and training process generally requiring a minimum of three to five years to complete, and includes verification of knowledge and skills through the successful completion of a national board exam, a clinical skills assessment process, continuing education and re-certification every three years, and specified levels of clinical experience in out-of-hospital settings. North American Registry of Midwives, *How to Become a CPM*, http://narm.org/certification/how-to-become-a-cpm/. It also notes that the American Public Health Association (APHA) recognizes this CPM training and clinical skills assessment process as the basis of a national certification program for licensing midwives who provide out-of-hospital maternity care services. *See* North American Registry of Midwives, *APHA Resolution*, http://narm.org/advocacy/apha-resolution/.

CPMs follow the practice standards of the National Association of Certified Professional Midwives (NACPM), another of the *amici* on this Brief. The NACPM standards limit the CPM scope of practice to the primary

maternity care of healthy women experiencing normal pregnancies. *See* National Association of Certified Professional Midwives, *Scope of Practice for the National Association of Certified Professional Midwives*, http://nacpm.org/about-cpms/professional-standards/scope-of-practice/ [hereinafter *Scope of Practice*]. As NACPM explains on its website, the Standards for Practice are among the NACPM set of "Essential Documents." National Association of Certified Professional Midwives, *Professional Standards & Competencies*, http://nacpm.org/about-cpms/professional-standards/ [hereinafter *Professional Standards*]. These include the Philosophy, Scope of Practice, and Standards of Practice, which were adopted by the NACPM Membership in 2004. *Id.* Several states in quick succession (Utah, Virginia, Wisconsin) referenced these Essential Documents in successful legislation to license CPMs in those states. NACPM defines the CPM Scope of Practice as follows:

> NACPM members offer expert care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. NACPM members work with women and families to identify their unique physical, social and emotional needs. They inform, educate and support women in making choices about their care through informed consent. NACPM members provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period. NACPM members are trained to recognize abnormal or dangerous conditions needing expert help outside their scope. NACPM members each have a plan for consultation and referral when these conditions arise. When needed,

> they provide emergency care and support for mothers and babies until additional assistance is available. NACPM members may practice and serve women in all settings and have particular expertise in out-of-hospital settings. *Scope of Practice*, *supra*.

As the professional society of CPMs, NACPM explicitly affirms the CPM credential on its website. According to NACPM, Certification as a CPM

> validates the knowledge, skills and abilities vital to responsible midwifery practice, and reflects and preserves the essential nature of midwifery care. The CPM credential is unique among maternity care providers in the United States as it requires training and experience in out-of hospital birth. The CPM credential allows multiple routes of entry to the profession to encourage innovation in education, adaptability to evolving best practices of the profession, diversity in the pool of credentialed midwives and broad accessibility to the profession. The competency-based model for certification assures well-educated, skilled and competent providers. National Association of Certified Professional Midwives, *The CPM Credential*, http://nacpm.org/about-cpms/who-are-cpms/the-cpm-credential/.

With respect to its Essential Documents, NACPM summarizes their fundamental roles as follows: "The NACPM Philosophy and the NACPM Scope of Practice are the foundation for the midwifery practice of the NACPM member. The NACPM Standards of Practice provide a tool for measuring actual practice and appropriate usage of the body of knowledge of midwifery." National Association of Certified Professional Midwives, *Standards of Practice for NACPM Members*, http://nacpm.org/about-cpms/professional-standards/standards-of-practice/.

B. Statutes Authorizing Licensing and Professional Regulation for CPMs

A growing trend shows state legislatures recognizing the value for their states in licensing CPMs and regulating direct-entry midwifery for the safety of women and babies in their state. The licensure trend is indicated in the Licensure Chart developed by the Big Push for Midwives Campaign of the National Birth Policy Coalition, another of the *amici* on this Brief. *See PushChart*, *supra*.

The Campaign works on public education and advocacy to increase access to licensed CPMs, in partnership with grassroots state organizations of midwives and consumers. According to the Campaign, the legislative decision to formally authorize midwives – as opposed to prosecuting them or prohibiting their practice – carries many advantages for a state and its residents. The Big Push for Midwives, *What We Do*, http://pushformidwives.org/what-we-do/. These include the fact that CPMs serve a disproportionate number of low-income, rural, immigrant, and uninsured families. The Big Push for Midwives, *Benefits of Licensing Certified Professional Midwives* (2014), http://pushformidwives.org/wp-content/uploads/2011/09/Benefits-of-CPM-Licensure.pdf. Regulation and licensure of CPMs ensures that there are enough well-trained midwives to

meet the demand for out-of-hospital birth and to provide safe and affordable maternity care for underserved populations. *Id.*

In addition, licensure and regulation of CPMs as autonomous practitioners provides a mechanism for families choosing out-of-hospital birth to verify their midwife's training, skills, and certification as a CPM. *Id.* CPM licensure also protects the health of American women and families by ensuring continuity of care, adherence to evidence-based practices, and transparency and accountability. *Id.* CPMs provide a family-centered model of maternity care that offers individualized education, counseling, screening, and prenatal care and includes continuous hands-on assistance during labor and delivery, as well as minimal use of costly technological interventions, with support of the physical, psychological, and social well-being of mothers and families throughout the childbearing cycle. *Id.*

CPM licensing laws also ensure that families can choose a birth provider and setting based on their religious, cultural, and philosophical beliefs. *Id.* Additionally, licensing CPMs helps to ensure the availability of qualified experienced out-of-hospital maternity care providers in the event an emergency makes hospital care inaccessible (e.g., a hurricane, epidemic, or other regional or national disaster). *Id.* Access to out-of-hospital maternity care is in keeping with the mission of the National Working Group for

Women and Infant Needs in Emergencies to ensure that the health care needs of pregnant women, new mothers, newborns and infants are adequately met during and after a disaster situation. *Id.*

No state that has enacted legislation to license CPMs has rescinded or repealed its law. *See PushChart*, *supra*. Several states, including Texas, Colorado, and Idaho, have reviewed their midwife licensing law during Sunset Review processes and, in each case, have reauthorized the program. It is anticipated that the steady progression of state licensing laws will continue, even quickening its pace, now that a majority of states have authorized the autonomous practice of CPMs.