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AMERICAN MIDWIFERY LITIGATION AND
STATE LEGISLATIVE PREFERENCES FOR
PHYSICIAN-CONTROLLED CHILDBIRTH

Stacey A. Tovino, J.D.*

“If you have the right to die at home, one would think you have the right to
be born at home.”1

From the colonial period to the Great Depression, lay midwives attended a
large proportion of deliveries that occurred in the United States.2 As late as 1900,
midwife-attended home births accounted for approximately one-half of all births in
the United States.3 By 1950, however, physicians attended more than eighty percent of all deliveries in the hospital setting.4

Historians have analyzed and interpreted birth statistics, medical textbooks,
medical school curricula, minutes of medical society meetings, public health
reports, articles in medical journals and popular magazines, letters from laboring
mothers, diaries of midwives, legislative committee reports, and state legislation to
identify issues of class, race, gender, and professional and economic competition
that may have played a role in physicians’ opposition to midwives and the transition from lay midwife-assisted home births to physician-assisted hospital births in the United States.5

This article analyzes and interprets an additional resource: the texts of
historical and recent court opinions that interpret state regulation of lay midwifery
practices. Why did courts consistently defer to legislative findings that high infant
and maternal mortality rates justified stringent regulation of midwives? Why do

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4 Id. See also Borst, supra note 2, at 1.

courts continue to uphold statutory requirements for physician supervision of midwives and statutes that restrict the practice of lay midwifery? To answer these questions, this article analyzes the history of the regulation of lay midwifery, as well as judicial opinions interpreting such regulation, in Alabama, Massachusetts, and California. Part I of this article generally discusses the history of lay midwifery in the United States, emphasizing the transition from home births attended by lay midwives to hospital births attended by physicians. Part II provides an overview of the legal regulation of lay midwifery in the United States. Parts III, IV, and V discuss the history of the practice and regulation of lay midwifery in Alabama, Massachusetts, and California, as well as judicial opinions interpreting these states’ frequently changing regulatory schemes. Parts III, IV, and V also place each judicial opinion within the historical context of the regulation of midwifery in the particular state and the United States as a whole. Part VI attempts to interpret the judicial opinions in light of issues relating to professional and economic competition, class, race, and gender. This article concludes that a confluence of forces likely has resulted in the judiciaries’ continued deference to state legislative preferences for physician-controlled childbirth and stringent regulation of midwives.

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I. HISTORY OF LAW MIDWIFERY IN THE UNITED STATES

A. The Social Era of Childbirth

Midwives delivered a large proportion of the babies born in the United States from the colonial period to the Great Depression.7 During the colonial period, childbirth was a “social”8 or “communal”9 event, not a medical event. Women relatives, friends, and neighbors, as well as midwives, attended, served, and assisted the laboring mother during her delivery.10 Most colonial period midwives began their practices by watching deliveries until they gradually assumed a more active role and “performed” as midwives when the usual midwife was delayed or was willing to allow a new midwife to perform.11 Even colonial period descriptions of the three stages of childbirth were in social, rather than medical or biological, terms.12 The midwife arrived first,13 followed by the women friends and neighbors of the laboring mother,14 and, finally, the after-nurse.15 Physician participation in childbirth during the colonial period was limited to only the most difficult births, including cases in which a physician and his instruments were needed to retrieve “lost” fetuses.16

Social healers, including midwives, were closely identified with their patients and moved “in and out of sickrooms unannounced, as though their presence there were the most ordinary thing in the world—as it was.”17 They developed personal affiliations and built local reputations.18 Eighteenth-century physician writers

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8 See, e.g., ULRICH, supra note 5, at 12 (explaining that the late eighteenth century “was the era of ‘social childbirth,’ when female relatives and neighbors, as well as midwives, attended births.”).
10 ULRICH, supra note 5, at 12.
11 Id.
12 Id. at 184-85.
13 Id.
14 See id. The arrival of the laboring mother’s relatives and friends generally signified the “imminence” of birth. Midwife Martha Ballard “explicitly linked a new intensity of labor with the summoning of the neighbors, writing that one woman’s ‘illness came on so great that her women were called.’” Id.
15 Id. at 183.
16 Suzanne Hope Suarez, Midwifery Is Not the Practice of Medicine, 5 YALE J. L. & FEMINISM 315, 325-26 (1993) (discussing the elimination of the American Midwife). See also ULRICH, supra note 5, at 59 (explaining that, “Unlike the surgeons of an earlier era, who were called only in dire emergencies, usually to dismember and extract an irretrievably lost fetus, late-eighteenth-century physicians considered it appropriate to officiate at an ordinary delivery.”).
17 ULRICH, supra note 5, at 61.
18 Id. at 61.
repeatedly referred to the laboring mother's attendants (the relatives, friends, and neighbors who were summoned) as "friends," which suggests that these women could "identify with their patients in ways that the male physicians could not."\(^{19}\) There is "[l]ittle wonder that some physicians actively resented their presence."\(^{20}\)

Few drugs and rudimentary surgical instruments were available to physicians during the eighteenth century.\(^{21}\) The technological simplicity of early medicine resulted in the ability of male physicians to offer little that could not also be offered by social healers.\(^{22}\) Accordingly, eighteenth-century midwives and physicians "sought—and generally achieved—similar results."\(^{23}\) A "system of cooperation" and "professional courtesy"\(^{24}\) existed between midwives and physicians for most of the eighteenth century. For example, author Laurel Thatcher Ulrich explains how Maine midwife Martha Ballard was invited to attend and observe an autopsy in 1789, which suggests that the local physicians may have considered her one player in the larger medical community, even if she was a subordinate player.\(^{25}\)

**B. The New Physician Obstetrics**

Although male physicians entered the practice of obstetrics in the United States as early as the second half of the eighteenth century,\(^{26}\) many of these physicians devoted only a portion of their professional lives to the practice of medicine. Significant time remained devoted to other occupations, such as land proprietorship and politics.\(^{27}\) Despite the male physicians' multiple occupations, some American women began to think that the men could provide services that midwives could not. Early nineteenth-century American physicians who had trained in Great Britain had access to education that social healers did not, and American physicians who did not train in Europe but were apprenticed-trained "carried with them the status advantages of their gender and of the popular image of superior education,"\(^{28}\) along with the ability to administer opium and use forceps, which promised improved health outcomes in the short term.\(^{29}\) For example, William Shippen, a British-trained physician, administered opium to

\(^{19}\) Id. at 65.
\(^{20}\) Id.
\(^{21}\) Id. at 54.
\(^{22}\) Id.
\(^{23}\) ULRICH, supra note 5, at 58.
\(^{24}\) Id. at 61 ("From the doctors' point of view, inviting midwives to observe [autopsies] was perhaps a professional courtesy, a way of including them in an important educational event.").
\(^{25}\) Id. at 54.
\(^{26}\) LEAVITT, supra note 3, at 38. In 1762, William Shippen returned from studying in London and Edinburgh and developed a series of midwifery lectures to train both female midwives and male physicians. Later, Shippen's lectures were limited to male students. Although Shippen may have been the most famous physician to have practiced midwifery in the eighteenth century, Shippen was not alone in history. Id. at 39. For example, Franklin Martin, for example, attended many deliveries during his training at Mercy Hospital in Chicago in the 1870's. Id. at 75.
\(^{27}\) Id. at 59.
\(^{28}\) LEAVITT, supra note 3, at 39.
\(^{29}\) Id.
relieve a laboring American woman’s suffering during a footling presentation of a 1795 birth.30

The minority of physicians who did receive formal medical training in the early nineteenth century attempted to elevate the prestige of their new specialty by emphasizing the importance of anatomy and physiology, although complications erupted in their practices.31 These complications were due in part to interventions, including bloodletting, drugs, and forceps.32 Inexperienced physicians sometimes used forceps unnecessarily, excessively, or inappropriately, which caused, among other conditions, severe perineal tears, cervical lacerations, recto and vesicovaginal fistulas, infections, and fetal damage.33 However, many women still believed that medical progress would eventually lead to reductions in birth dangers and pain.34

C. The Exclusivity of the Medical Profession

In 1820, a Harvard Medical School professor published an anonymous treatise in which he argued that women’s characters would be ruined if they became familiar with medical instruction, including dissections:

It is needless to go on to prove this; it is obvious that we cannot instruct women as we do men in the science of medicine; we cannot carry them into the dissecting room and the hospital; many of our more delicate feelings, much of our refined sensibility must be subdued, before we can submit to the sort of discipline required in the study of medicine; in females they must be destroyed; and I venture to say that a female could scarce pass through the course of education requisite to prepare her, as she ought to be prepared, for the practice of midwifery, without destroying those moral qualities to character, which are essential to the office.35

The professor’s argument that women should not be instructed as men suggests that the eighteenth-century system of cooperation and professional courtesy between midwives and physicians was giving way to the exclusiveness of the medical profession in the nineteenth century. Unlike earlier physicians who maintained multiple occupations as proprietors, politicians, and physicians,36 nineteenth-century physicians began practicing medicine full-time.37 Although the

30 Id. Footling presentation is defined as the “presentation of the fetus in labor with one of both feet prolapsed into the vagina.” Id. at 274.
31 Id. at 43.
32 Id.
33 LEAVITT, supra note 3, at 43-57. See also Diana Scully, From Natural to Surgical Event, in THE AMERICAN WAY OF BIRTH 52, (Pamela S. Eakins ed., 1986) (discussing the dangers associated with inappropriately used forceps during delivery).
34 LEAVITT, supra note 3, at 58.
35 See ULRICH, supra note 5, at 251 (quoting Walter Channing, REMARKS ON THE EMPLOYMENT OF FEMALES AS PRACTITIONERS IN MIDWIFERY (1820)).
36 See ULRICH, supra note 5, at 59-60.
37 Id. at 177 (“For Martha Ballard the behavior of Dr. Page was particularly troubling. The young man was not yet twenty-four years old and still unmarried, yet he seemed bent on making midwifery a
younger physicians may have saved some women from the dire consequences of complicated labors, a laboring woman’s chances of survival did not, on the whole, increase during the nineteenth century.38

Factors contributing to the change from cooperation and professional courtesy between midwives and physicians to medical exclusivity in the nineteenth century were not only “fashion and forceps”39 but as demonstrated by the Harvard Medical professor’s treatise: (1) changing notions of womanhood; (2) a new kind of male professionalism based on the full-time practice of medicine; and (3) a unified system of medicine in which “ordinary” and “emergency” practices merged.40 Laurel Thatcher Ulrich concludes that these factors:

[D]emanded the elimination or further subordination of social healers. To allow a woman to continue to practice midwifery, or, by extension, any other form of independent healing, deprived male doctors of the experience they needed and at the same time perpetuated the notion that un-educated people could safely care for the sick.41

Although physicians increasingly attended the deliveries of women around the turn of the century, many individuals still believed that no difference existed between the skill of the male physician and the midwife.42 When J. Whitridge Williams, an obstetrics professor at Johns Hopkins Medical School, reviewed the School’s obstetrics curriculum in 1912, he concluded that, “the average practitioner, through his lack of preparation for the practice of obstetrics, may do his patients as much harm as the much-maligned midwife.”43 Thus, obstetrical skill and the application of general obstetrical principles varied widely depending on the practitioner and his or her training.44

In the late nineteenth-century, the “old and the new” continued to mingle in birthing rooms.45 Although laboring women invited male physicians into their homes, hoping to benefit from the physicians’ new medical expertise and technology, female relatives and neighbors continued to provide some delivery assistance.46 The status of the late nineteenth-century physician in the mother’s home, vis-à-vis her friends, may have been elevated by the physician’s ability to use the new obstetrical techniques,47 but tension between the mother’s physician and friends still existed. For example, a Long Island physician armed with

part of the full-time practice of medicine.”).

38 Id. at 57.
39 Id. at 180 (“Historians have attributed the rise of ‘male-midwifery’ in England and America to two factors, fashion and forceps.”).
40 Id. at 254.
41 Id. at 254.
42 BORST, supra note 2, at 1.
43 LEAVITT, supra note 3, at 63. Williams discovered that most medical students only had the opportunity to witness the delivery of one woman during their schooling.
44 Id. at 63.
45 Id. at 59.
46 Id. at 59.
47 Id.
information about germ transmission was treated with hostility in 1890 when he suggested that the women attendants boil his instruments and make a clean bed for the delivery.\textsuperscript{48} The laboring physicians and friends likely compromised on many procedures until the twentieth century, when "physician-directed obstetrics finally became master of the birthing room."\textsuperscript{49}

\textbf{D. The Rise of Hospital Births}

Midwife-attended home births accounted for approximately one-half of all births in the United States as late as 1900.\textsuperscript{50} However, during and after the period from 1910 to 1930, many women moved to the hospital to deliver their babies.\textsuperscript{51} By 1940, fifty-five percent of births in the United States occurred in the hospital.\textsuperscript{52} By 1950, eighty-eight percent of births occurred in the hospital,\textsuperscript{53} and midwives attended less than ten percent of all deliveries.\textsuperscript{54} After 1950, physicians, including many who had received special training in obstetrics, attended more than eighty percent of all deliveries in the United States.\textsuperscript{55} Physician attendance at hospital deliveries became so prominent that the transition has been described as follows:

In just half a century, allopathic physicians in the United States have enticed ninety-nine percent of us into their places of business (hospitals) for childbirth, forced on us a medical model of birth... raised the price of services... and lobbied state legislatures for laws that would require us to submit to their exclusive control during pregnancy and childbirth.\textsuperscript{56}

The transition to physician-attended hospital deliveries in the twentieth century first began with middle- and upper-class women and their obstetricians who believed in new theories regarding germ transmission that theoretically made home birth difficult to manage.\textsuperscript{57} Popular medical journals in the 1920's and 1930's also encouraged women to deliver their babies in hospitals to ensure the safety of both mother and child.\textsuperscript{58} At that same time, specialists (vis-à-vis general practitioners) attempted to monopolize obstetrical cases, and hospital-based obstetricians aggressively managed childbirth by using pain-relieving drugs, labor inducers, and other technological interventions.\textsuperscript{59} By the second wave of the women's movement in the 1960's, American physicians had established a near-monopoly on

\textsuperscript{48} LEAVITT, supra note 3, at 60.
\textsuperscript{49} Id. at 61.
\textsuperscript{50} Id. at 12. Around 1900, the number of physician-attended deliveries increased and approximately equaled the number of midwife-attended deliveries. Id. After 1900, the number of physician-attended deliveries increased while the number of midwife-attended deliveries decreased. Id.
\textsuperscript{51} Id. at 82.
\textsuperscript{52} LEAVITT, supra note 3, at 171.
\textsuperscript{53} Id.
\textsuperscript{54} Id. at 12.
\textsuperscript{55} Id. See also BORST, supra note 2, at 1.
\textsuperscript{56} Suarez, supra note 16, at 315.
\textsuperscript{57} LEAVITT, supra note 3, at 173.
\textsuperscript{58} Id. at 178.
\textsuperscript{59} Id. at 179-80.
childbirth, although the percentage of out-of-hospital births did increase slightly to approximately one percent of all births by 1975.

The trends described in the preceding paragraphs did not apply to all populations in the United States. For example, the black population in the South, as well as the immigrant population that came to the United States at the end of the nineteenth century, delivered a greater proportion of babies at home in the attendance of midwives for a longer period of time. Part III, infra, which discusses the regulation and practice of lay (and mostly black) midwives in Alabama in the middle of the twentieth century, as well as Part IV, infra, which begins with a story about turn-of-the-century Massachusetts midwife Hanna Porn, will illustrate departures from these national statistics.

II. CURRENT LEGAL STATUS OF MIDWIFERY IN THE UNITED STATES

Each state has the power to regulate the midwives who practice in that state, and most states have enacted laws that identify whether the practice of midwifery is permitted, prohibited, or restricted. In addition, most states distinguish between "lay" midwives, also referred to as "direct-entry," "independent," or "granny" midwives [hereinafter lay midwives], and nurse-midwives [hereinafter nurse-midwives]. Lay midwives generally do not have

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62 Lowis & McCaffery, supra note 60, at 21.

63 Indeed, in 1935, although only five percent of white pregnant women were attended by midwives, fifty-four percent of black pregnant women were attended by midwives. By 1953, both races' use of midwives dropped: only three percent of white women, and twenty percent of black women, were attended by midwives during their deliveries. Id. at 24.

64 Although state statutes and regulations generally regulate midwives, the Federal Government has recognized the practice of midwifery by allowing its insurance plans, including the Medicaid Program and the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) Program, to provide reimbursement for professional services rendered by midwives. See 42 U.S.C. § 1396d (Medicaid permits reimbursement of midwives); 10 U.S.C.A. § 1079 (CHAMPUS permits reimbursement of midwives).

65 Other schemes that prohibit or restrict the practice of midwives include the: (1) denial or restriction of reimbursement by third party insurers; (2) denial or limitation of hospital admitting privileges; and (3) restriction of access to physician affiliation. See Barbara A. McCormick, Childbearing and Nurse-Midwives: A Woman's Right to Choose, 58 N.Y.U. L. REV. 661, 674 (1983) (discussing the various schemes that restrain the trade of midwives). These schemes generally are beyond the scope of this article. However, the restriction of access to physician affiliation is briefly discussed in Part V, which addresses California obstetricians' failure to formally agree to supervise licensed midwives, as required to permit lay midwives to practice under the California Licensed Midwifery Practice Act of 1993. For a thorough discussion of the antitrust implications of the denial of hospital privileges to nurse-midwives, see Brenda J. Glaser-Abrams, Hospital Privileges for Nurse-Midwives: An Examination Under Anti-Trust Law, 33 AM. U. L. REV. 959 (1984).

66 The Midwives Alliance of North America (MANA) categorizes midwives as lay midwives, certified nurse-midwives, or certified professional midwives. Lay midwives usually have no formal education in the field of childbirth, but have gained proficiency in birthing through practice and apprenticeship pursuant to which they share a fund of common knowledge from more experienced midwives. Certified nurse-midwives must first acquire a nursing degree and then complete further study
nursing degrees; instead, they have gained proficiency in birthing through practice and apprenticeship\(^6^7\) Although lay midwives historically relied on self-education and apprenticeship, many lay midwives today combine apprenticeship with some type of training at a school for lay midwives, like the Seattle Midwifery School.\(^6^8\)

Certified nurse-midwives, on the other hand, must first acquire a nursing degree and then complete further study in standard gynecology and obstetrics before they may attend deliveries. Although certified nurse-midwives are expressly permitted to work in all fifty states, certified nurse-midwives generally practice only in institutional settings under the direct control of physicians due to state statutory and regulatory constraints. For example, as discussed in more detail in Part IV, infra, Massachusetts only permits certified nurse-midwives to work under the supervision of a licensed physician in licensed health care facilities.

Thus, each state regulates the practice of lay midwifery differently. States usually regulate the practice of midwifery under the auspices of specific nurse-midwife licensure acts, although some states do so more generally through their medical practice acts, and other states do so more specifically through new lay midwifery licensure acts. As will become evident in Parts III, IV, and V, infra, the primary stated justification for state regulation of lay midwives is the protection of the public from unqualified, incompetent practitioners.

Although both lay and nurse-midwives have challenged the constitutionality of various state regulatory provisions, the courts, with few exceptions,\(^6^9\) have

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\(^6^8\) Id.

\(^6^9\) In those cases in which the regulation of midwives was not upheld, the courts usually found that certain administrative regulations promulgated by state agencies were invalid exercises of delegated legislative authority. See, e.g., Dep't. of Health & Rehabilitative Serv. v. McTigue, 387 So.2d 454 (Fla. App. 1980). In McTigue, the Florida appellate court held that certain administrative rules, which required the supervising physician to be licensed in Florida and required the applicant for the license to practice midwifery to list the names of patients to be delivered by the midwife, were invalid exercises of delegated legislative authority. The court specifically reasoned that the Florida Department of Health and Rehabilitative Services was not authorized to add or to modify those provisions of the statute that identified with particularity the criteria that must be satisfied for an individual to be eligible for a license to practice midwifery.
upheld the provisions. For example, judges in Massachusetts,\textsuperscript{70} New Jersey,\textsuperscript{71} New York,\textsuperscript{72} Pennsylvania,\textsuperscript{73} and Illinois\textsuperscript{74} have ruled that the regulation of midwifery does not violate a midwife's due process rights. In addition, a 1976 California decision refused to extend the constitutional right to privacy, which had already been established in the areas of procreation and abortion, to an expectant mother's choice of the manner and circumstances in which her baby would be born, including her choice of childbirth attendants.\textsuperscript{75} Moreover, a 1987 Massachusetts decision upheld the constitutionality of a Massachusetts statutory provision that established certification requirements for nurse-midwives and prohibited nurse-midwives from attending home births (even though the statute did not similarly restrict lay midwives) against an equal protection challenge.\textsuperscript{76} Finally, courts have upheld statutes requiring nurse-midwives to be licensed and to practice only in certain licensed facilities in the face of challenges based on illegal restraint of trade under both federal and state anti-trust law.\textsuperscript{77}

III. ALABAMA: THE PROMINENCE OF BLACK LAY MIDWIVES UNTIL 1976

\textit{A. Introduction to Alabama Medicine and Midwifery}

When Booker T. Washington arrived in Alabama in 1881, he found no licensed black physicians, pharmacists, or dentists practicing in the state.\textsuperscript{78} However, in the mid-1880's, Cornelius Nathaniel Dorsett, a black man, passed

\textsuperscript{70} Leigh v. Bd. of Registration, 481 N.E.2d 1347 (Mass. 1985), aff'd, 506 N.E.2d 91 (Mass. 1985) (holding that a Massachusetts statute that regulated nurse midwives did not violate the plaintiff nurse's due process rights when the Massachusetts Board of Registration disciplined the nurse for violating the statute by practicing midwifery without having first obtained the proper certification).

\textsuperscript{71} Sammon v. N.J. Bd. of Med. Exam., 66 F.3d 639 (3rd Cir. 1995) (holding that a New Jersey statute regulating midwives did not violate the substantive due process rights of either aspiring midwives or women who desired to employ midwives in subsequent pregnancies because the statute was rationally related to New Jersey's legitimate state interests in protecting the health and welfare of mothers and children).

\textsuperscript{72} Lange-Kessler v. N.Y. Dept. of Educ., 109 F.3d 137 (2d Cir. 1997) (holding that the New York Professional Midwifery Practice Act, which requires midwives to obtain a formal education and to enter into a written practice agreement with a licensed physician or hospital, was rationally related to the legitimate interest of the State of New York of protecting the health and welfare of mothers and infants).

\textsuperscript{73} Firman v. Bd. of Med., 697 A.2d 291 (Pa. Commw. Ct. 1997) (holding that the likelihood of erroneous deprivation of a nurse-midwife's property interest in her license was negligible under the Pennsylvania Medical Practice Act's automatic suspension provisions, which suspended nurse-midwifery licenses upon conviction of drug-related felonies).

\textsuperscript{74} People ex rel. Sherman v. Cryns, 786 N.E.2d 139 (Ill. 2003) (holding that the Illinois Nursing and Advanced Practice Nursing Act was designed to protect the health and safety of the public and, therefore, that the plaintiff, an "alleged" midwife, who was enjoined from continuing her unlicensed practice of midwifery following a water delivery that resulted in the death of a newborn, was not denied her liberty and property interest in her employment as a lay midwife).

\textsuperscript{75} Id.

\textsuperscript{76} See Leigh, 395 Mass. at 683 (reasoning that Massachusetts stated a legitimate purpose in assuring a minimal level of training and competence for nurse-midwives as one way to permit consumers to rely on such board certification when making informed decisions about health care).

\textsuperscript{77} See id.

\textsuperscript{78} SMITH & HOLMES, supra note 1, at 20.
Alabama's medical licensure examination; and in 1891, the Alabama Medical Society licensed its first woman physician, Dr. Halle Tanner Dillon Johnson.

During the nineteenth century, most black women in Alabama delivered their babies in the attendance of local, usually black, midwives rather than in the attendance of the few black physicians licensed to practice medicine in Alabama. The use of black midwives appeared to have been influenced by the mothers' rural isolation, race, and economic situations, not by preference. Indeed, while speaking at the Nineteenth Annual Meeting of the Alumnae Association of the Woman's Medical College of Pennsylvania, Dr. Johnson explained that Alabama families living far from town could not afford care by a physician because most physicians charged money for travel (two dollars per mile for a visit) in addition to the cost of medicine. Many of these physicians required payment by cash or reliable assurances of payment before they would travel to attend to a person who lived far from town.

In addition, many white doctors and hospitals refused to care for poor black women before desegregation. Although several small hospitals in Birmingham, Montgomery, Selma, and Tuskegee offered medical care to blacks, black women who lived in rural areas failed to use these hospitals because they were "unfamiliar, far away, and costlier than midwife care." Accordingly, most black women in Alabama relied on local black midwives to attend their deliveries in the nineteenth century and in the first half of the twentieth century. Although only fifteen percent of all births in the United States in 1930 were attended by midwives, eighty percent of those midwives lived in the South, including Alabama.

One black lay midwife who practiced in Alabama throughout the middle of the twentieth century was Margaret Charles Smith, the subject of the autobiography Listen to Me Good: The Life Story of an Alabama Midwife, and Alabama's oldest living midwife in 1996, the date of the book's publication. Following the birth of her first two children, Mrs. Smith began attending births with a lay midwife named Ella Anderson. After several years of accompanying Anderson on

79 Id.
80 Id.
81 Id.
82 Id. at 35.
83 Id. at 20.
84 SMITH & HOLMES, supra note 1.
85 Id. at 104.
86 Id. at 35.
87 Id. at 20-21, 37.
88 See LEAVITT, supra note 3, at 268.
89 SMITH & HOLMES, supra note 1.
90 Mrs. Smith was born in Eutaw, Alabama, on September 12, 1906. Id. at xvii. Unmarried, Mrs. Smith gave birth to her first two children in 1922 and 1926, at the ages of sixteen and twenty, respectively. Id. At the age of thirty-six, Mrs. Smith married her husband, and her third son was born a year later. Id. at 44.
91 Id. at 75.
deliveries, Mrs. Smith began attending deliveries of relatives and friends. Mrs. Smith initially used castor oil, lard, and other lubricants to rub the abdomens of laboring mothers, and other “birthing pharmacopia” including black haw, black pepper, mayapple root, ginger root, dirt dauber or spider webs, and tread sash tea.

B. Lay Midwives and Permits

Although early studies showed that maternal and infant mortality rates were about the same in the early twentieth-century for black Alabama women whose deliveries were attended by midwives and white Alabama women whose deliveries were attended by physicians, black midwives were still associated with high mortality rates. In 1928, Jessie L. Marriner, the Director of Public Health Nursing in Alabama, stated that although midwifery was a “time-honored institution in Alabama,” formal midwife education and registration should be required to protect the public health. Thus, in the early twentieth century, Alabama health officials initiated efforts to increase access to prenatal care and to regulate midwives.

In 1918, the Alabama Legislature enacted a law that required all midwives to pass an examination and register with the Alabama State Board of Health, which prompted the Andrew Memorial Hospital in Tuskegee to offer to train Alabama’s black midwives. The Tuskegee facility emphasized simple hygiene and domestic skills including making beds, preparing foods, and giving baths. Although thousands of women practiced as lay midwives in Alabama, only a few completed the required training.

After years of attending the deliveries of Alabama women without any formal education or training, Mrs. Smith in 1949 became one of Greene County, Alabama’s last lay midwives to receive training and to receive an official permit for the practice of midwifery. After receiving her training, Mrs. Smith was recruited by local physicians and became a part of Greene County’s public health team by working in public health prenatal clinics (including clinics in Boligee, Tishibe, and Eutaw, Alabama), which provided prenatal care to approximately twelve percent of Alabama women. Mrs. Smith was permitted to attend the deliveries of clinic patients who had received prenatal care if she received permission from a clinic physician in the form of a written card that was signed by

92 Id.
93 Id. at 37.
94 SMITH & HOLMES, supra note 1, at 37-38.
95 Id. at 64.
96 Id. at 63.
97 Id. at 64.
98 Id.
99 Id.
100 SMITH & HOLMES, supra note 1, at xvii.
101 Id. at 67. White women accounted for only 2.3 percent of the population of women who attended the prenatal clinics, “as clinic care was viewed a last resort for poor blacks and a federal imposition of socialized medicine.” Id. at 65.
the physician:

See, they don’t allow midwives to deliver unless the doctor writes out a statement. My name is signed to the bottom of the card. You can’t go unless they bring the paper to you first. Then, you have the paper, and the doctor signed it. I’d been trained all along not to fool with somebody unless a doctor O.K.’d the paper stating that the patient is O.K. for a midwife.102

Mrs. Smith’s back-up physician, who praised her skills and her rare decisions to seek physician referrals, was Dr. Ruker Staggers.103 For the twenty-eight year period between 1949 and 1977, Mrs. Smith worked at the various public health prenatal clinics and attended the deliveries of hundreds of patients.104

Although a strong body of American medical opinion opposed to midwives and their “low status” clients existed,105 such opinions were not uniformly held. For example, Mrs. Smith’s supervising physicians continually praised her skills and her excellent health outcomes. One interpretation is that less competitive and more courteous attitudes grew out of the general southern belief that although midwifery could not be raised to the level achieved in Europe and, especially, Great Britain, “it was realistic to aim at requiring minimal acceptable standards of midwifery, and that this would have to suffice.”106 A second interpretation is that white Alabama physicians were less competitive with black Alabama midwives whose patients were mostly poor, black women, because many of these women could not afford to pay the lower midwife rate, let alone the higher physician rate. According to this interpretation, physicians had no reason to compete with midwives for patients. Mrs. Smith’s autobiography, which contains a number of references to her substantial efforts to collect amounts owed her for midwifery services, supports this interpretation.107

Although the training provided to Alabama midwives by the government was very basic, physicians and health authorities favored midwives who had completed the training. However, many midwives still relied on their own considerable experiences and skills, not the government training:

Midwives like Mrs. Smith took their new training into their souls, but they also used skills and knowledge they had acquired in apprenticeships with

102 Id. at 78.
103 Dr. Staggers recalled, “Margaret’s babies did awfully well. I can’t think of any time when there was any question about Margaret’s babies. But we knew that if Margaret needed us ... there was something going on that needed some help.” Id. at 88.
104 Id. at 77.
105 SMITH & HOLMES, supra note 1, at 21.
106 Lois & McCaffery, supra note 60, at 22. See also LAY, supra note 67, at 61 (noting that most southerners felt that “if, somehow, midwives could be made to wash their hands and to use silver nitrate drops for the babies’ eyes’ that was all that could be expected.”).
107 SMITH & HOLMES, supra note 1, at 75-76 ("Some of the children, I meet them now, they've grown and gone. Mama ain't [sic] never paid me, Daddy ain't [sic] never paid me. I just give it to them. I'm short.").
community midwives. While sometimes counting on miracles in a crisis, Mrs. Smith recognized that her skills were the bottom line. Training emphasized reliance on medical backup, but midwives had to be self-reliant because they faced old barriers: institutional segregation, gender discrimination, and professional elitism.\textsuperscript{108}

Mrs. Smith herself stated the following with respect to the formal training: “I took the training courses, but the midwife had already trained me, Ella Anderson.... But everything, everything I learned, I learned from Miss Anderson. See, Miss Ella Anderson had done learned me, and I didn’t forget it.”\textsuperscript{109}

In addition to the training, examination, and registration requirements, local health departments, acting under direction of the Alabama State Board of Health, also required midwives to adhere to certain rules identified in each local health department’s \textit{Manual for Midwifery Training} which, among other rules: (1) required newborn babies to be placed in separate sleeping quarters from their mothers, even if a cardboard box was the only other option; (2) prohibited the use of any drugs (including the traditional herbs carried by Mrs. Smith and other midwives) other than castor oil or another laxative to bring on labor; (3) prohibited the application of grease to the mother’s abdomen or birth canal, reflecting concerns for reducing infections; and (4) permitted frequent inspections of midwives’ bags for illegal drugs, including teas and roots.\textsuperscript{110}

In 1931, Alabama county health departments supervised the 3,568 Alabama midwives who, by that time, had completed the required training.\textsuperscript{111} Many of these midwives worked in state-sponsored public health prenatal clinics.\textsuperscript{112} These midwives attended the majority of births by black women as well as an increasing number of births by white women due in part to the depressed economic conditions and the laboring mother’s preference for midwives.\textsuperscript{113}

\textbf{C. Improved Health Outcomes, the “Midwife Problem,” and Racial Inequities}

Despite the growing concern of the white Alabama medical establishment regarding the “midwife problem,” many pregnant women benefited from increased access to maternity care, including the care provided by the midwives who worked at rural health clinics during the 1930’s and 1940’s. When the Alabama Bureau of Maternal and Child Health sponsored a quality-of-care study, it identified positive

\textsuperscript{108} \textit{Id.} at 68.

\textsuperscript{109} \textit{Id.} at 75.

\textsuperscript{110} \textit{Id.} at 87. As officials inspected midwifery bags more frequently, some midwives would prepare one bag for inspection and another bag that they would actually bring with them when they attended a delivery. The bag the midwife would bring to deliveries might actually contain, in addition to legal drugs like castor oil, other oils to be mixed with sugar and turpentine for healing small cuts, as well as herbal roots. \textit{Id.} at 87. \textit{See also} SMITH \& HOLMES, \textit{supra} note 1, at 101 (explaining how nurses who were caught carrying illegal teas in their midwifery bags would be asked to turn in their midwifery bags).

\textsuperscript{111} SMITH \& HOLMES, \textit{supra} note 1, at 64.

\textsuperscript{112} \textit{Id.}

\textsuperscript{113} \textit{Id.} at 65.
outcomes for the black women enrolled in prenatal clinics whose deliveries were attended by midwives.\textsuperscript{114} The \textit{Alabama Medical Journal}, in its report of the quality-of-care study, concluded that:

If we take the two opposite extremes economically and educationally, namely, the white (non-clinic) patient and the colored clinic patient, it is rather startling to find the colored rate is lower than the white in maternal mortality by 9 percent and neonatal mortality by 35 percent, but higher in stillbirths by 13 percent, probably in the main because of the prevalence of syphilis in the colored.\textsuperscript{115}

Although black Alabama midwives had earned the respect of both the black and white women whose deliveries they attended,\textsuperscript{116} most white physicians, local health authorities, and the local medical establishment still refused to recognize black midwives as health care providers in part because of their race.\textsuperscript{117} An article published in \textit{Alabama Medical Transactions} in 1935 stated, “The midwife problem becomes more pernicious as the years roll by. We reported last year that the number of mothers taken care of by midwives was on the increase, and we regret to say it continues to increase.”\textsuperscript{118}

One interpretation is that the midwives’ fees began to attract the attention of the medical establishment. According to Mrs. Smith, the nurses at the Alabama State Board of Health established the fees that the registered midwives could receive for attending a delivery of a clinic patient.\textsuperscript{119} When midwives began earning sufficient fees, Mrs. Smith believes that the state and the medical profession’s efforts to eliminate the midwives increased: “See, the nurses at the health department set the prices we got paid. It started off at five, then it went to ten, to fifteen, to twenty. When it got on up there to fifty, that’s when they wanted the midwives off.”\textsuperscript{120}

At the same time, racial abuses and attitudes of racial superiority were continuing. For example, Tuskegee sponsored a syphilis blood-testing program for black men, the result of which was to deny medical treatment to those men who tested positive for the disease.\textsuperscript{121} By further example, early twentieth-century American physicians believed that the high rate of syphilis among Alabama’s black

\begin{footnotes}
\item[114] \textit{Id.} at 65-66.
\item[115] \textit{Id.} at 65-66.
\item[116] \textit{Id.} at 21.
\item[117] SMITH \& HOLMES, supra note 1, at 21, 23.
\item[118] \textit{Id.} at 65.
\item[119] \textit{Id.} at 75.
\item[120] \textit{Id.} at 76-77.
\end{footnotes}
population was the result of excessive sexual desire. With this background of racial abuses and attitudes, historians argue that the efforts of white physicians and the medical establishment to eliminate midwives were similarly "clouded" by attitudes of racial superiority. For example, in the 1940's, white physicians directed specific campaigns towards white women in an attempt to persuade them not to have their births attended by black midwives, despite the white women's respect for the skills of their black midwives. The control of and racial bias towards Alabama midwives continued later in the twentieth century as well. For example, in the 1960's and 1970's, black lay midwives were criticized for failing to use blood pressure cuffs. However, the county health departments, which included white administrators, physicians, and nurses, refused to train the black midwives in the use of the blood pressure cuffs on the grounds that only nurses could use them.

D. Act 499

Despite lay midwives' safe delivery of thousands of Alabama babies and the improvement of health outcomes in the women who received prenatal care at the local health departments' prenatal clinics, the Alabama legislature passed a new law in 1976 that ended the legal practice of lay midwifery. The relevant portion of this law [hereinafter Act 499] provides:

(a) It shall be unlawful for any person other than a licensed professional nurse who has received a license from the State Board of Nursing and the Board of Medical Examiners to practice nurse midwifery in this state. Any person violating this subsection shall be guilty of a misdemeanor. (b) Nothing in subsection (a) of this section shall be construed as to prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery as heretofore provided until such time as said permit may be revoked by the county board of health.

Paragraph (a) of Act 499 continued to allow nurse-midwives to practice hospital-based midwifery in Alabama as long as they obtained and maintained the appropriate licensure. However, paragraph (b) "grandfathered in" lay midwives

122 SMITH & HOLMES, supra note 1 at 67; Brandt, supra note 121, at 393.
123 SMITH & HOLMES, supra note 1, at 21, 67.
124 Id. at 145.
125 Id.
127 Even nurse midwives were not allowed to plan to attend deliveries at a home. Act 499 specifically states, "All deliveries must be planned to take place in the hospital." Id. § 34-19-8.
128 However, even nurse midwives were not permitted to "undertake the charge of abnormal cases of confinement or any disease in connection with confinement" or to "perform manipulations of any kind." See id. §§ 34-19-7 and 34-19-8. Indeed, nurse midwives were only permitted to attend cases of "normal childbirth." Id. § 34-19-8. Act 499 defines "normal childbirth" as "[d]elivery, at or close to term, of a pregnant woman whose physical examination by a physician reveals no abnormalities." Id. § 34-19-2(3). Moreover, if the laboring mother does not deliver her baby within a "reasonable time," the nurse midwife is required to notify a qualified physician immediately and must "make no effort to
who had been issued permits by local boards of health and allowed them to continue to engage in the practice of lay midwifery, but only "until such time as said permit may be revoked by the county board of health." 129 Accordingly, to the extent the local boards of health refused to renew lay midwives' old permits, or to issue new permits, lay midwives' practices became illegal.

Indeed, lay midwives' non-underground practices all but ended within five years of the passage of Act 499. 130 "[C]ounty health departments made renewal of lay midwife permits extremely difficult." 131 Some physicians refused to sign lay midwives' new permits, and some local health boards effectively retired currently registered lay midwives by refusing to renew their registrations. 132 No Alabama county health department issued a lay midwife permit after 1977. 133 In addition, Alabama counties began enforcing old, ignored rules that prohibited any individual over the age of sixty-five from practicing midwifery. 134

After decades of practice, more than 150 Alabama midwives, all of whom were black, received letters or visits from physicians or nurses informing them that they could no longer practice midwifery. 135 In one case, a nurse simply "dropped by" the home of a lay midwife who had been practicing in Mobile County since the 1920's and told her that "she was no longer a midwife." 136 Mrs. Smith remembers that, "They wrote me at the health department that I couldn't be no more midwife [sic]. I had to bring my bag and my equipment in, not only me, but all of them that was delivering." 137

The elimination of lay midwifery in Alabama was effectuated with little organized resistance. 138 Alvin Holmes, the legislator who co-sponsored the bill that became Act 499, remembers "little controversy" surrounding 499's enactment. 139 Even though lay midwives had worked under the auspices of local health departments since 1918, the midwives did not have the political clout to organize opposition to Act 499. By the 1980s, the majority of Alabama women delivered their babies in the hospital setting 140 and, today, Alabama women do not have the legal right to choose any type of midwife (even a nurse-midwife) to attend

deliver the child except under the authorization and supervision of such physician." Id. § 34-19-8.
129 Id. § 34-19-3(b).
130 SMITH & HOLMES, supra note 1, at 134.
131 Id.
132 Id.
133 Id. at 135.
134 Id.
135 SMITH & HOLMES, supra note 1, at 135.
136 Id.
137 Id. at 145.
138 Id.
139 Id. at 134.
140 Alabama women who relied on Medicaid benefits, which were established by the federal government in 1965, could not be attended by lay midwives because Medicaid only paid for deliveries attended by physicians or nurse-midwives. See 42 U.S.C. § 1396d(a)(17) (2001) (explaining that the medical assistance provided under the Medicaid Program includes services furnished by a nurse-midwife that the nurse-midwife is legally authorized to perform under State law).
E. Upholding Act 499 against Constitutional Challenges: State v. Kimpel

For most lay midwives, the idea of establishing or maintaining an underground lay midwifery practice following the enactment of Act 499 was not possible. However, Mrs. Smith, and perhaps a few other lay midwives, did practice for a few years after Act 499 was passed until their permits expired and, even after that, until their back-up physicians ceased referring patients to them. Mrs. Smith explains:

But I think Dr. Staggers helped me as long as he could. I have to give him credit for that. He would let people come through with their girls fixing to have a baby. Some of them have their babies out thee in the front yard, in the car. Then I’d have to get on the phone to call him. He’d tell me to fix them up, carry them on home, and come on by the office.... That was called underground. I reckon I did that for so long, and then I quit because people began to talk.

Mrs. Smith attended her last delivery in 1981. Although Mrs. Smith stopped practicing midwifery in 1981, a few Alabama midwives did not. Research reveals one published Alabama court opinion, issued in 1995, in which a woman was charged with violating Act 499. In State v. Kimpel, the State of Alabama charged Toni Darlene Kimpel in five separate indictments with practicing nurse midwifery without a license in violation of Act 499. In an unpublished decision, the trial court held that Act 499’s provisions were “vague and ambiguous” and, therefore, unconstitutional. The State of Alabama appealed the trial court’s decision to the Court of Criminal Appeals of Alabama, and it is this court’s published decision that is available to the public.

Unfortunately, the Court of Criminal Appeal’s written opinion does not state Ms. Kimpel’s race, age, or the areas of Alabama in which she maintained her midwifery practice, although the issuance of the indictments by the Mobile County grand jury suggests that Ms. Kimpel practiced in Mobile County. The court does explain that Ms. Kimpel never possessed a health department permit to practice lay midwifery, as did Mrs. Smith. The court further states its belief regarding why lay midwives no longer have permits: “In fact, no one possesses a valid health department permit for the practice of lay midwifery. This provision

141 SMITH & HOLMES, supra note 1, at 143.
142 Id. at 140.
143 Id. at 146.
144 Id. at xvii.
146 Id. at 991-92.
147 See id.
148 See id.
149 Id. at 994.
was grandfathered in the 1975 Code. All those who previously held the permits have terminated their practice, and the health department no longer issues such permits." 150 Interestingly, the Court's language suggests that lay midwives voluntarily terminated their practices and then the health department ceased issuing new permits. 151 However, the midwives did not voluntarily cease their practices; instead, health department officials refused to renew their permits and ultimately told each remaining lay midwife, by letter or in person, that their practices had to be discontinued. 152

The indictments issued by the Mobile County grand jury provide further insight into the nature of Ms. Kimpel's allegedly illegal activities, which appeared to include typical prenatal care and delivery attendance services: "Toni Darlene Kimpel... did, by agreement or contract for payment or other payment or consideration, provide care, management, evaluation, examinations, pre-natal care, advice and assistance as a nurse midwife during the pregnancy and delivery of a child...." 153

During the legal proceedings, Ms. Kimpel first challenged her indictment based on her assertion that she practiced lay midwifery, rather than nurse midwifery, and that Act 499 was unconstitutionally vague when applied to lay midwives. 154 Ms. Kimpel argued that because the phrase "nurse midwifery" is defined in Act 499, and because the phrase "lay midwifery" appears in Act 499 but is not defined, Act 499 did not prohibit her specific lay midwifery practice. 155 The Court of Criminal Appeals of Alabama disagreed and overturned the trial court's decision, explaining that Act 499 "clearly prohibits a narrowly defined class of conduct. We therefore find that this statute is neither vague nor ambiguous." 156

Ms. Kimpel's second challenge to the indictment was predicated on her assertion that Act 499 constituted an invasion of a pregnant woman's right to privacy because Act 499 prohibited a pregnant woman from choosing a lay midwife to attend a home birth. 157 Although the Court recognized the United States Supreme Court's 1973 decision in Roe v. Wade, which extended the penumbra of the constitutional right to privacy derived from the First, Fourth, Fifth, Ninth, and Fourteenth Amendments to a woman's right to request a physician to perform an abortion during her first trimester of pregnancy, the Court disagreed with Ms. Kimpel's argument. 158 Instead, the Court cited a 1975 California opinion and a 1991 Colorado opinion for the principle that, under Roe v. Wade, a woman's constitutional right to privacy does not extend to choosing the manner of childbirth,

150 Id. at 994 n.3
151 See Kimpel, 665 So.2d at 994 n.3.
152 SMITH & HOLMES, supra note 1, at 135-45.
153 Kimpel, 665 So.2d at 993.
154 Id.
155 Id. at 993-94.
156 Id. at 994.
157 Id.
158 Id.
including the presence of a midwife.\textsuperscript{159}

Ms. Kimpel's third and final challenge to the indictment was predicated on her assertion that Act 499 violated her right to equal protection under the law.\textsuperscript{160} The Court disagreed that lay midwives do not constitute a suspect class and therefore, the proper standard of review was whether Act 499 was rationally related to a legitimate government objective:

The Alabama statute regulating the practice of midwifery does not involve a suspect class. Furthermore, as illustrated above, in discussing Roe, protection of the safety of a mother and child during labor and delivery is a legitimate government objective. Therefore, this statute does not violate the equal protection guarantees of either the federal or our state constitution.\textsuperscript{161}

The constitutional freedom to choose a profession is generally evaluated by the rational basis constitutional standard of review in court cases. To satisfy the rational basis standard, the state must offer a legitimate state interest that is rationally related to the restrictions imposed by the law in question.\textsuperscript{162} In evaluating the rational basis test, courts are extremely deferential to the legislature's intent and judgment. However, the Kimpel Court's opinion fails to address the fact that all of the 150 midwives who lost their permits were black, and that race is a suspect class for purposes of Constitutional analysis.\textsuperscript{163} The proper standard of review for statutes that directly target, or have a disparate impact on, a suspect class is the strict scrutiny test.\textsuperscript{164} The strict scrutiny test requires an analysis of whether the questioned legislation is necessary to achieve a compelling state interest. Whether the Court would have upheld Act 499 under the more

\textsuperscript{159} Kimpel, 665 So.2d at 994. (citing People v. Rosburg, 805 P.2d 432 (Colo. 1991) and Bowland v. Mun. Court for Santa Cruz County, 556 P.2d 1081 (Cal. 1975)).

\textsuperscript{160} Id.

\textsuperscript{161} Id.


\textsuperscript{163} Between 1976 and 1981, over 150 black Alabama midwives lost their permits to practice. Smith & Holmes, supra note 1, at 2, 135.

\textsuperscript{164} Even in those states in which lay midwives are not predominantly black, one could argue that an intermediate standard of constitutional review, which is more stringent than the "rational relationship" test, but less stringent than the "strict scrutiny" test, would be applicable. The intermediate standard of constitutional review, which asks whether the state legislation serves "important" governmental objectives and is "substantially related" to the achieving of those objectives, is used to analyze allegedly discriminatory gender-specific statutes. For example, in United States v. Virginia, the United States Supreme Court, in reviewing the State of Virginia's categorical exclusion of women from the Virginia Military Institute, declared that the state must produce an "exceedingly persuasive justification" in order to allow a gender-discriminating law to stand. 518 U.S. 515, 531 (1996). In Kimpel, one could have made the argument that when a professional field like midwifery has been traditionally, and is currently, composed of one sex, that profession has adopted that gender's definition and identification and, therefore, the applicable level of constitutional scrutiny should be the intermediate level of scrutiny. Whether Kimpel's attorneys raised this issue is unclear, although unlikely, due to the fact that in the opinion, the court clearly utilizes the rational basis standard of review. The success of a gender-based argument likely would have been limited due to the fact that most midwifery statutes do not limit the profession to women.
stringent scrutiny analysis is unclear. However, the Court’s failure to identify Act 499’s true effect on black lay midwives is telling.

After disagreeing with all three of Ms. Kimpel’s assertions, the Court of Criminal Appeals of Alabama ultimately reversed the trial court’s decision dismissing the indictments and ordered the trial court to restore the indictments to the trial docket for appropriate disposition.165

IV. MASSACHUSETTS: EARLY BAN OF MIDWIFERY

A. Nineteenth-Century Massachusetts Medicine

Massachusetts was the “center” of opposition to midwifery at the turn of the century.166 In 1915, a Pennsylvania physician stated, “I know of no other section of the country which has been more successful in prohibition [of midwives] than Massachusetts.”167 The State’s opposition to midwives may be explained, in part, by the classification of midwives with other types of irregular168 practitioners including Thomsonians and homeopathists.169 “Regular physicians sought to edge out competitors, including women practitioners and other rivals they lumped together as ‘irregulars’ and discredited as ‘quacks.’”170

Perhaps as a result of these efforts, Massachusetts passed its Medical Practice Act in 1894, which established guidelines for the examination and licensing of physicians.171 Importantly, the 1894 Medical Practice Act considered obstetrics a medical practice that required licensing.172 Moreover, the Medical Practice Act

165 Kimpel, 665 So.2d at 994.
166 Declercq & Lacroix, supra note 5, at 376.
167 Id.
168 Research for case law involving lawsuits against midwives revealed many cases that did not involve lawsuits against midwives, but that were identified simply because the word “midwife” was in the same sentence as the phrase “irregular practitioner.” See, e.g., Monohan v. Divinny, 225 N.Y.S. 601, 604 (Sup. Ct. 1927) (noting that the term “malpractice” has been applied not only to duly licensed physicians and surgeons, “but to irregular practitioners as well, and also to nurses, midwives, and apothecaries”).
169 In the early nineteenth-century, many Americans turned away from conventional, but harsh, medical treatments including bleeding and purging. Instead, they embraced milder, less debilitating therapeutic regimens. Samuel Thomson, a leading spokesman of this movement, explained that he learned of botanic medicine from a female herbalist who cured his wife after an allopathic physician had failed to do so. Thomson believed that the common cold brought on an illness that restored the body’s natural heat and, thus, cured the cold. After a decade of local practice, Thomson outlined his principles in his 1822 book, New Guide to Health; or Botanic Family Physician. See SAMUEL THOMSON, NEW GUIDE TO HEALTH; OR BOTANIC FAMILY PHYSICIAN (1835), portions reprinted in MAJOR PROBLEMS IN THE HISTORY OF AMERICAN AND PUBLIC HEALTH 71-73 (John Harley Warner & Janet A. Tighe eds., 2001). Thomsonian medicine, named after Samuel Thomson, was originally egalitarian and anti-elitist, in keeping with the spirit of the Jacksonian era. See JOHN S. HALLER, MEDICAL PROTESTANTS: THE ECLECTICS IN AMERICAN MEDICINE, 1825-1939 (1994), available at Dittrick Medical History Center, http://www.cwru.edu/arctic/dittrick/artifactspages/a-3certifc.htm (last visited Dec. 7, 2003).
171 Secretary of the Commonwealth of Massachusetts, Acts and Resolves of the State of Massachusetts ch. 458, § 11 (1894).
172 Id.
equated midwifery with obstetrics. Thus, a lay midwife who attended home deliveries or used any instruments or carried any drugs and was not also licensed as a physician would violate the Medical Practice Act.\footnote{173}{Id.}

Three years after Massachusetts passed its Medical Practice Act, the state passed its 1897 Birth Registration Act, which required physicians and midwives to report all of the births they had attended to the local city clerk.\footnote{174}{Eugene R. Declercq, The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts, 84 AM. J. PUB. HEALTH 1022, 1026 (June 1994).} The combination of the 1894 Medical Practice Act and the 1897 Birth Registration Act created a Catch 22 for midwives. Stated another way, midwives who failed to register births would be considered to have violated the 1897 Birth Registration Act, and midwives who appropriately registered births under the 1897 Birth Registration Act would be considered to have engaged in the unlicensed practice of obstetrics and, thus, the unlicensed practice of medicine in violation of the 1894 Medical Practice Act.\footnote{175}{Id.} Although the 1894 and 1897 legislation curbed the practices of some lay midwives, other midwives, including several whose practices were located in Lawrence, Massachusetts, continued to attend home deliveries until at least 1914.\footnote{176}{Id.}

B. The Prosecution of Massachusetts Midwife Hanna Porn

The numerous legal battles by Massachusetts midwife Hanna Porn provide some insight into the competition midwives faced in the late nineteenth and early twentieth centuries. Hanna Porn was born in Finland in 1860 and arrived in Gardner, Massachusetts in 1895.\footnote{177}{Id.} In 1896, Porn traveled to Chicago where she attended the Chicago Midwife Institute, “from which she received a diploma, which stated that she had received theoretical and practical instruction in the art of midwifery for a period of six months, and was declared a graduated midwife.”\footnote{178}{Id.} After graduating, Porn returned to Gardner, Massachusetts, to establish her midwifery practice. Porn recorded her first delivery attendance in February 1897.\footnote{179}{Id.} In the next eleven years, Porn recorded over six hundred births, which is more than the number of births recorded by all at the time except for one physician in Gardner.\footnote{180}{Id.} Most of Porn’s clients were other immigrant women, mainly from the Finnish, Russian, and Swedish communities, all of whom were of the working class.\footnote{181}{Id.} An important factor in Porn’s clients’ decisions to use Porn was likely cost. Porn only charged two to five dollars for her entire package of midwifery services, which included delivery attendance and after-care visits every day to the

\footnote{173}{Id.}
\footnote{174}{Eugene R. Declercq, The Trials of Hanna Porn: The Campaign to Abolish Midwifery in Massachusetts, 84 AM. J. PUB. HEALTH 1022, 1026 (June 1994).}
\footnote{175}{Id.}
\footnote{176}{Id.}
\footnote{177}{Declercq, supra note 174, at 1023.}
\footnote{178}{See Commonwealth v. Porn, 82 N.E. 31 (Mass. 1907).}
\footnote{179}{Declercq, supra note 174, at 1023.}
\footnote{180}{Id.}
\footnote{181}{Id. See also Corcoran, supra note 66, at 649 (describing the Commonwealth v. Porn decision).}
new mother and baby for a minimum of one week as well as cooking and cleaning services during that week.\textsuperscript{182} Porn's fee was approximately one-third of the fees charged by local Gardner physicians for delivery attendance alone. Statistics demonstrated that the babies delivered in Porn's attendance were twice as likely to survive as babies delivered by local Gardner physicians.\textsuperscript{183}

Despite Porn's success, the State of Massachusetts formally charged Porn on July 27, 1905, with the criminal act of illegally practicing medicine.\textsuperscript{184} The charges were not initiated by an injured or unhappy client of Porn's; instead the charges were brought by Edwin B. Harvey, M.D., the executive secretary of the Massachusetts Board of Registration in Medicine (the "Board").\textsuperscript{185} The Board complained that Porn "held herself out as a midwife and practiced midwifery, but did not claim to be a general practitioner of medicine, nor was she lawfully authorized to practise [sic] medicine," all of which violated the 1894 Medical Practice Act.\textsuperscript{186} As discussed above, the Massachusetts Medical Practice Act did not distinguish between the scope of practice of a midwife and a physician, although the Supreme Judicial Court of Massachusetts noted that it would have been within the power of the Massachusetts Legislature to "separate by a line of statutory demarcation the work of the midwife from that of the practitioner in medicine."\textsuperscript{187}

During Porn's 1907 trial, physicians testified on behalf of the Board that midwifery was synonymous with obstetrics and, therefore, that unlicensed and untrained midwives should be prevented from attending deliveries.\textsuperscript{188} The Board emphasized the following additional facts:

[Porn] delivered many women in childbirth for compensation, and carried with her to her patients the usual obstetrical instruments, which she used rarely on occasions of emergency, but never if a physician could be called in time. She used six printed prescriptions or formulas in treating her patients, which contained directions for their application, and the purposes for which they were used, as follows: 'For vaginal douche,' 'For postpartum hemorrhage,' 'To prevent purulent ophthalmia in the newborn,' 'For afterpains,' 'For uterine inertia,' and 'For painful hemorrhoids or piles.' She used no other prescriptions or formulas.\textsuperscript{189}

Interestingly, the 1907 Supreme Judicial Court of Massachusetts looked to "medical and popular lexicographers" for a definition of "midwife," and found that "midwife" meant "female obstetrician" and that "midwifery" was equivalent to the

\textsuperscript{182} Id.
\textsuperscript{183} Id.
\textsuperscript{184} Commonwealth v. Porn, 81 N.E. 305 (Mass. 1907) (evidentiary decision); Commonwealth v. Porn, 82 N.E. 31 (Mass. 1907) (substantive decision).
\textsuperscript{185} Declercq, supra note 174, at 1024.
\textsuperscript{186} Porn, 82 N.E. at 31.
\textsuperscript{187} Id. at 32.
\textsuperscript{188} Declercq, supra note 174, at 1024-25.
\textsuperscript{189} Porn, 82 N.E. at 31.
“practice of obstetrics.” The Court concluded that, “This goes far toward showing that obstetrics is a branch of the practice of medicine”.\footnote{190}{Id.}

It requires no discussion to demonstrate that, when, in addition to ordinary assistance in the normal cases of childbirth, there is the occasional use of obstetrical instruments, and a habit of prescribing for the conditions described in the printed formulas which the defendant carried, such a course of conduct constitutes a practice of medicine in one of its branches. Although childbirth is not a disease, but a normal function of women, yet the practice of medicine does not appertain exclusively to disease, and obstetrics as matter of common knowledge has long been treated as a highly important branch of the science of medicine.\footnote{191}{Id.}

In summary, the physicians who controlled the Massachusetts Board of Registration in Medicine contended that midwifery was the same as obstetrics and convinced the Massachusetts Supreme Judicial Court of this as well.

As a final effort, Porn argued that the 1894 Medical Practice Act’s midwifery ban was unconstitutional as “class legislation” because, if the Act was construed to prohibit the practice of midwifery, the practices of other classes of practitioners were not also prohibited by the then-current provisions of the Act.\footnote{192}{Porn, 81 N.E. 305 (citing MASS. R.L. c.76, § 8, now MASS. GEN. LAWS ch. 112, § 6 (2004)).} Stated another way, Porn argued disparate treatment of midwives as a profession. Porn based her argument on a provision in the 1894 Medical Practice Act that excluded from the prohibition on unlicensed medical practice “clairvoyants or persons practicing hypnotism, magnetic healing, mind cure, massage, Christian science cosmopathic method of healing,”\footnote{193}{Michael H. Cohen, State Law Regulation of the Practice of Medicine: Implications for the Practice of Complementary and Alternative Medicine, (Nancy Fass, ed., 2000), available at http://www.michaelhcohen.com/article7.html (Dec. 8, 2003).} but not midwives. Without further discussing Porn’s class legislation claim, the Court simply stated, “[The Act’s] validity cannot be questioned on this ground. The maintenance of a high standard of professional qualifications for physicians is of vital concern to the public health, and reasonable regulations to this end do not contravene any provision of the State or Federal Constitution.”\footnote{194}{Porn, 82 N.E. at 32.} Although the Massachusetts Supreme Judicial Court noted that Porn was “of good character and reputation,” it ultimately concluded that her actions constituted criminal violations of the Medical Practice Act.\footnote{195}{Id. }Although Hanna Porn was convicted in the 1907 case as well as several other cases, Porn continued to serve her working class immigrant client base.\footnote{196}{Declercq, supra note 174, at 1027.} Throughout 1907, Porn’s midwifery practice grew steadily and, in December of 1907, she was arrested again. Porn went to trial in 1908 and she was ultimately sentenced to a
$100 fine and three months jail time.\textsuperscript{197}

Porn endured ten trials in all, but remained "unwavering in her commitment to safer, more comprehensive, and affordable maternity care in her community."\textsuperscript{198} Of the ten cases filed against Porn, not one was brought by a client. Instead, all of the cases were initiated by medical professionals who were members of the Massachusetts Board of Registration in Medicine who, perhaps, viewed Porn's practice as infringing on their client base. Porn's unwillingness to terminate her practice may have increased opposition by the Gardner medical community and the Massachusetts medical establishment. Interestingly, Porn seems to have had the last word. "Her 1913 obituary noted that she was employed as a 'private nurse' at an address where, according to local vital records, a baby boy was born on the day she died."\textsuperscript{199}

Statistics suggest one reason why physicians in Massachusetts felt the need to prosecute Hanna Porn despite her good reputation and positive health outcomes. Midwives attended 19.9 percent of all births in Massachusetts in 1900. However, this percentage more than doubled by 1908, when midwives attended 41.3 percent of all births.\textsuperscript{200} During this period, the number of physician-attended deliveries dropped.\textsuperscript{201} In addition, the number of different midwives attending deliveries increased.\textsuperscript{202} In 1896, only one midwife (Louise Beck) delivered the 327 reported midwife-attended deliveries.\textsuperscript{203} By 1913, more than a dozen midwives attended the registered births, which numbered almost 100 births per month, with the busiest midwife (Minnie Riehm) accounting for only 18 percent of all midwife-attended deliveries.\textsuperscript{204} Perhaps the Massachusetts physicians felt uncomfortable with such a high number of practicing midwives.\textsuperscript{205} If only one or two midwives practiced, they could be shut down at any time. However, with so many midwives running such active practices, the exclusiveness of the Massachusetts medical profession over childbirth may have been threatened.

\textbf{C. The Immigrant Midwives of Lawrence, Massachusetts}

The 1894 and 1897 Massachusetts legislation curbed the practices of some lay midwives. However, other midwives, including several practicing in Lawrence, Massachusetts, continued to attend home deliveries.\textsuperscript{206} The 1894 and 1897

\begin{footnotesize}
\textsuperscript{197} See Discrimination against Midwives, \textit{at} http://www.students.haverford.edu/wmbweb/writings/rlmidwives.html/#notes (last visited Dec. 7, 2003); Declercq, \textit{supra} note 174, at 1027.
\textsuperscript{198} Corcoran, \textit{supra} note 66, at 649.
\textsuperscript{199} \textit{Id.}
\textsuperscript{200} Declercq & Lacroix, \textit{supra} note 5, at 382-83.
\textsuperscript{201} \textit{Id.} at 383.
\textsuperscript{202} \textit{Id.}
\textsuperscript{203} \textit{Id.}
\textsuperscript{204} \textit{Id.}
\textsuperscript{205} \textit{Id.}
\textsuperscript{206} Declercq & Lacroix, \textit{supra} note 5, at 377-78 ("Midwifery practice continued and, as the example of Lawrence will illustrate, flourished openly in some areas for almost a decade after the Porn decision.").
\end{footnotesize}
legislation did not have an immediate impact on the practice of lay midwifery in Lawrence.

For example, in 1907, the year the Massachusetts Supreme Judicial Court issued its published opinion in Commonwealth v. Porn, three midwives in Lawrence—Virginia Pedrazzini, Angelina DeMarco, and Laura Carpenito—attended thirty-nine registered births.\(^{207}\) In 1913, six years following the Porn case, these three women attended 442 births and registered all of them with the Lawrence City Clerk.\(^{208}\) Eugene Declercq explains the confluence of several factors that contributed to the popularity of midwives in Lawrence, Massachusetts during that time period: (1) the immigrant status of the population; (2) the lack of a local hospital providing obstetrical services; (3) the quality of care provided at a limited cost by the midwives; (4) the midwives’ use of advertising; and (5) the midwives’ ability to circumvent the laws.\(^{209}\)

The limited fees the Lawrence midwives charged is an important factor. The standard cost for midwifery services in Lawrence was five dollars, which included “attendance at confinement, simple nursing care, help in the household duties and general nursing and oversight of the home until such time as she is able to resume her work.”\(^{210}\) Lawrence midwives provided daily checkups for a period of approximately eight to ten days after the delivery of the baby, while physicians only provided one or two visits after the delivery.\(^{211}\) Like Maine midwife Martha Ballard who accepted food, cloth, ribbons, and dressmaking services in exchange for her midwifery services,\(^{212}\) many Lawrence midwives also accepted payment of food or services as an “in kind” payment.\(^{213}\) Lawrence physicians, on the other hand, wanted “their ten dollar fee in cash.”\(^{214}\)

Because neither the 1894 nor the 1897 legislation appeared to have any immediate effect on the Lawrence midwives, the Massachusetts physicians attempted to influence public opinion against them by educating the public to select physicians for their deliveries instead of midwives.\(^{215}\) In addition to public education, the Massachusetts Legislature also attempted to directly regulate physicians’ involvement with midwives. First, the legislature passed a 1912 amendment to the 1897 Birth Registration Act, which required physicians to indicate on birth returns whether they had personally attended a birth.\(^{216}\) The 1912 legislation added an additional line to the birth registration form that read, “I did

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\(^{207}\) Id. at 376.

\(^{208}\) Id.

\(^{209}\) Id. at 385-87.

\(^{210}\) Id. at 387.

\(^{211}\) Id.

\(^{212}\) ULRICH, supra note 5, at 86-90.

\(^{213}\) Id.

\(^{214}\) Declercq & Lacroix, supra note 5, at 387.

\(^{215}\) Id. at 378.

\(^{216}\) Id. at 377.
(doctor's name) personally attend this birth." The implication of this amendment is that physicians who collaborated with midwives would be identified through birth registration records. Second, the Legislature passed a 1917 amendment to the 1894 Medical Practice Act that prohibited a physician from "act[ing] as a principal or assistant in carrying on the practice of medicine by an unregistered person," and would impose a one-year license revocation for those who assisted unlicensed individuals with the practice of medicine.

Although neither piece of legislation single handedly eliminated midwifery in Lawrence, a combination of the "legal restrictions, physicians' opposition, the greater influx of foreign born doctors, the rise in hospital births, the passage of restrictions on immigration in the 1920's, and the assimilation of immigrants resulted in the diminution of midwifery practice."

D. 1975 Nurse-Midwifery Legislation

After Massachusetts passed its 1894 Medical Practice Act, which made the practice of lay midwifery illegal, more than three-quarters of a century passed before the state permitted nurse-midwives to practice under the supervision of a licensed physician in a health care facility. In 1975, the Massachusetts Legislature added the following statutory provision, entitled "An Act Providing for the Practice of Nurse-Midwifery," to its General Laws: "A nurse-midwife [licensed under Massachusetts law]... may engage in the practice of nurse-midwifery; provided, however, that the nurse-midwife functions as a member of a health care team which includes a qualified physician licensed to practice medicine in the commonwealth which physician has admitting privileges in a [licensed hospital]...."

Regulations adopted in 1980 to implement the 1975 legislation further prohibited any person from practicing as a nurse-midwife without first obtaining the Board's authorization to do so. The combination of the legislation and the implementing regulations permitted nurses to practice as nurse-midwives with the Board's specific authorization. Even then, however, authorized nurse-midwives could only practice in a health care facility and only under the supervision of a licensed physician. Thus, the legislation expressly prohibited a nurse-midwife from attending a home delivery. In addition, the legislation did not expressly regulate lay midwives, which became the subject of an opinion written by the Supreme Judicial Court of Massachusetts in 1985 in Leigh v. Board of Registration in Nursing.

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217 Id. at 388.
218 Id. at 379.
219 Id. at 389.
220 See 1975 Mass. Acts. ch. 846, § 2, adding MASS. GEN. LAWS ch. 112, § 80C. See also id. § 80B, which provides, "Nursing practice involves clinical decision making leading to the development and implementation of a strategy of care to accomplish defined goals... including certified nurse midwives."
221 MASS. REGS. CODE tit. 244, § 4.11.
222 Leigh v. Board of Registration of Nursing, 481 N.E.2d at 1347 (Mass. 1985).
E. Constitutional Challenges to Massachusetts' Nurse-Midwifery Legislation

In *Leigh v. Board of Registration of Nursing*, Janet Leigh, a Massachusetts licensed registered nurse whose license had been continuously in effect since May 1, 1970, attended to a woman's delivery (in the woman's home) on September 23, 1982. Importantly, Leigh had never applied to the Massachusetts Board of Registration in Nursing (the Board) for authorization to practice as a nurse-midwife, and therefore, she was not a certified nurse-midwife. Complications arose during the labor, and Leigh called an ambulance and accompanied the woman to the hospital. At the hospital, Leigh gave the admitting physician the patient's history, which is presumably how the Board became aware of Leigh's home birth practice. The receiving hospital or emergency room physician likely reported Leigh to the Board.

After reviewing the case, the Board concluded that Leigh was a registered nurse engaged in the unauthorized practice of midwifery in violation of both the 1975 Massachusetts legislation and its 1980 implementing regulations and suspended her license to practice nursing for one year. In her defense, Leigh first argued that she was only engaged in the practice of lay midwifery, which was outside the practice of nursing and distinct from nurse-midwifery. Second, Leigh argued that she was not engaged in the unauthorized practice of medicine. The Board disagreed, responding that Leigh failed to rebut the argument that she violated the regulations controlling the conduct of nurses acting as midwives. The Board argued and the Court agreed that the 1975 legislation did not distinguish between lay midwifery and nurse-midwifery, even though the 1975 legislation did not expressly speak to lay midwifery.

The Court further explained that the result would have been different had Leigh not been a nurse and, instead, was just any other unlicensed person:

There is no statutory prohibition against the practice of lay midwifery by lay persons. The Legislature has not regulated midwifery by persons other than nurses. Nor do we interpret our case law to prohibit the practice of midwifery as the unauthorized practice of medicine. In *Commonwealth v. Porn*... the court upheld the conviction of a midwife for the unauthorized practice of medicine. However, the basis of her conviction was not her practice of midwifery per se but the fact that she used 'the usual obstetrical instruments'.... This court stated: 'When, in addition to ordinary childbirth assistance in the normal cases of childbirth, there is the occasional use of obstetrical instruments... such a course of conduct constitutes a practice of medicine in one of its branches.'.... Thus, 'ordinary

223 *Id.*
224 *Id.* at 1349.
225 *Id.*
226 *Id.* at 1350.
227 *Leigh*, 481 N.E.2d at 1351.
228 *Id.*
assistance in the normal cases of childbirth,' which we interpret to mean the practice of midwifery, would not be considered the practice of medicine.229

Leigh also attacked the constitutionality of the 1975 legislation, arguing that the legislation: (1) violated the fundamental right of privacy of a mother to choose where and with whom she will give birth; (2) offended due process of law because the legislation deprives Leigh of her right to practice her profession and lacks a rational basis; and (3) violated the guarantee of equal protection of the laws.230

Summarily stating that the 1975 legislation did not prohibit lay individuals (i.e., non-nurses) from attending home deliveries, the Court did not consider Leigh’s constitutional privacy argument any further. With respect to Leigh’s due process argument, the Court simply stated that the 1975 legislation bears a "reasonable and substantial relation to the public health, safety, morals, or some other phase of the general welfare."231 Finally, with respect to Leigh’s equal protection argument, the Court simply deferred to the Massachusetts Legislature, stating that "[t]he Legislature apparently concluded that nurses needed training beyond their nursing training in order to practice midwifery."232 The 1985 Supreme Judicial Court of Massachusetts ultimately remanded the case to the Board for further consideration.233

After the Board reconsidered the decision at the direction of the Supreme Judicial Court, the Board again suspended Leigh for practicing midwifery in violation of the 1975 legislation and the 1980 implementing regulations.234 Leigh appealed the Board’s decision, and the Supreme Judicial Court of Massachusetts analyzed Leigh’s appeal in a second 1987 opinion.235 In this appeal, Leigh re-argued her equal protection claim more specifically, emphasizing that the law prohibits nurses and nurse-midwives from attending home births but does not similarly restrict lay midwives.236 The Court responded again with deference to the Legislature:

The Legislature has expressed its preference that births attended by nonphysicians take place in licensed facilities with the assistance of certified nurse midwives... The fact that the Legislature has not enacted legislation regulating lay midwives does not render the statute regulating nurse midwives unconstitutional. The equal protection clause does not require the government to choose between attacking every aspect of a

229 Id. at 1353.
230 Id. at 1354.
231 Id. (quoting Sperry & Hutchinson Co. v. Director of the Div. on the Necessaries of Life, 307 Mass. 408, 418 (Mass. 1940)).
232 Id. at 1355.
233 Leigh, 481 N.E.2d at 1356.
234 See Leigh v. Board of Registration in Nursing, 506 N.E.2d 91 (Mass. 1987) [hereinafter "Leigh II"].
235 Id.
236 Id. at 92.
problem or not attacking it at all... The State has a legitimate purpose in assuring a minimal level of training and competence in nurses licensed by the board so that consumers may rely on the board certification in making informed decisions about health care.\footnote{See 1957 Cal. Stat. Ch. 363, § 10102, at 1181, 1995 Cal. Stat. Ch. 415, § 4, at 79 (requiring parents to complete the birth certificate in the event that a physician does not attend a birth at home).}

On appeal, Leigh renewed her privacy claim and further argued that the 1975 legislation illegally restrained trained midwives in violation of federal and Massachusetts antitrust law.\footnote{Id.} The Court summarily decided that actions of the Massachusetts Legislature and of the Board were sovereign actions of the State, which are exempt from antitrust liability.\footnote{Leigh II, 506 N.E.2d at 95.} The 1985 Court ultimately disagreed with all of Leigh’s claims and ordered the trial court to affirm the original decision of the Board to suspend Leigh’s license to practice as a registered nurse.\footnote{Leigh, 481 N.E.2d at 1356.}

V. CALIFORNIA: LICENSED LAY MIDWIVES PERMITTED TO ATTEND HOME DELIVERIES UNDER PHYSICIAN “SUPERVISION”

A. The History of the Regulation of Midwives in California: 1915-1975

California’s regulation of midwifery has an extremely checkered history. In 1915, the California Legislature enacted a law that required midwives to complete birth certificates and register midwife-attended births that were not also attended by a physician.\footnote{1915 Cal. Stat. Ch. 378, § 13, at 581 (providing for the registration of all births and deaths and requiring the physician or midwife attending births to file the birth certificate).} The law specifically stated:

In each case where a physician, or midwife, or person acting as midwife, was in attendance upon birth, it shall be the duty of such physician to file in accordance herewith the certificate herein contemplated. In case no physician was in attendance, it shall be the duty of the midwife or person acting as midwife to file such certificate.\footnote{Id.}

This requirement remained in effect until 1957, when the Legislature deleted the word “midwife” from the statute, which resulted in the parents being the only individuals permitted to register births that occurred unattended by a physician.\footnote{See 1957 Cal. Stat. Ch. 363, § 10102, at 1181, 1995 Cal. Stat. Ch. 415, § 4, at 79 (requiring parents to complete the birth certificate in the event that a physician does not attend a birth at home).}

Midwifery proponents criticized the 1957 revision because parental registration of planned midwife-attended home-births resulted in the documentation and reporting of an “unassisted birth,” which skewed the statistics regarding the safety of planned, midwife-attended births.\footnote{Happe, supra note 66, at 723-4.}

In 2000, the California Legislature amended the California Health and Safety

\footnotesize{\textsuperscript{237} Id. at 93.\textsuperscript{238} Id. at 94-95.\textsuperscript{239} Leigh II, 506 N.E.2d at 95.\textsuperscript{240} Leigh, 481 N.E.2d at 1356.\textsuperscript{241} Id. at 93.\textsuperscript{242} Id. at 94-95.\textsuperscript{243} Id. at 94-95.\textsuperscript{244} Id. at 94-95.\textsuperscript{245} See 1957 Cal. Stat. Ch. 363, § 10102, at 1181, 1995 Cal. Stat. Ch. 415, § 4, at 79 (requiring parents to complete the birth certificate in the event that a physician does not attend a birth at home).\textsuperscript{246} Happe, supra note 66, at 723-4.}
midwifery practice which Legislature believed public to exclude made assist and "Act", entitled statutory Code to permit a licensed midwife, in the absence of a physician, to prepare and register birth certificates for live midwife-attended births that occurred outside of hospitals or alternative birthing centers. Specifically, the Legislature amended Section 102415 of the California Health & Safety Code to provide:

For live births that occur outside of a hospital or outside of a state-licensed alternative birth center... the physician in attendance at the birth or, in the absence of a physician, the professionally licensed midwife in attendance at the birth or, in the absence of a physician or midwife, either one of the parents shall be responsible for entering the information on the certificate, securing the required signatures, and for registering the certificates with the local registrar.

The California Legislature also regulated the practice and certification of midwives. In 1917 and 1937, the California Legislature enacted and amended a statutory scheme, set forth in the California Business and Professions Code and entitled “Healing Arts” [hereinafter California “Medical Practice Act” or the “Act”], which authorized the issuance of certificates to individuals allowing the practice of medicine or surgery, podiatry, and midwifery. Midwifery was then, and still is, defined in California as “the furthering or undertaking by any person to assist a woman in normal childbirth.” One of the provisions within the Act made the uncertified practice of midwifery a misdemeanor.

In 1949, the California Legislature amended its Medical Practice Act to exclude midwifery from the group of practices for which new certificates could be issued. This change followed new developments in obstetric medicine and public education efforts designed to encourage women to deliver in what was believed to be the safer and less painful hospital environment. However, the Legislature maintained the provisions defining midwifery, the practices authorized under a midwifery certificate, and the provisions designating the conditions under which a midwife’s certificate could be revoked. The inference to be drawn from the retention of these provisions is that the Legislature intended to prohibit the practice of midwifery without a certificate, while permitting the practice of midwifery under an unrevoked certificate issued before 1949.

In 1975, the California legislature passed new provisions to be placed in the

245 Id. at 723.
246 CAL. HEALTH & SAFETY CODE § 102415 (Deering 2004).
247 See 1917 Cal. Stat., Ch. 81, § 8, pp. 96-7; 1937 Cal. Stat., Ch. 399, § 2135, p. 1258.
248 See id.
249 Former CAL. BUS. & PROP. CODE § 2140 (Deering 1937).
250 Id. at § 2141.
252 Leavitt, supra note 3, at 178 (noting that throughout the 1920's and 1930's, “popular journals as well as medical journals urged women to go to the hospital to receive the best possible obstetrical care and to insure the safety of both mother and child.”).
Medical Practice Act that provided for the certification of midwives. From 1975 to 1993, the California Legislature specifically regulated the practice of nurse midwives by requiring certification, but did not specifically regulate lay midwives.

B. Bowland and Northrup: The Practice of Lay Midwifery in California Constitutes the Unlicensed Practice of Medicine

Although the California Legislature’s silence with respect to lay midwives arguably could have been interpreted as establishing an “a-legal” (not legal but not illegal) status for lay midwives, California courts reviewed charges filed against lay midwives for practicing medicine without a license in violation of the California Medical Practice Act in 1976 and, again, in 1987. In both cases, the California courts determined that the lay midwives were practicing medicine without a license contrary to the provisions of the California Medical Practice Act because they were holding themselves out as diagnosing and treating the physical condition of pregnancy.

In Bowland v. Municipal Court, a 1976 decision by the Supreme Court of California, the State of California had charged three women who held themselves out as midwives but who were not nurses (and who, therefore, had not obtained certificates from the State permitting them to attend deliveries as certified nurse-midwives) with the unlicensed practice of medicine under the State’s Medical Practice Act. All three women had worked at the Santa Cruz Birth Center, which was created in 1971 in part because no physician in Santa Cruz County would provide prenatal care to a woman who planned a home delivery. In Bowland, the State specifically alleged that from October 25, 1973, through March 6, 1974, each woman “did willfully and unlawfully hold herself out as practicing a system or mode of treating the sick or afflicted to wit: such practices as undertaking to assist and treat a woman in childbirth....” In so doing, the State relied on then-current § 2140 of the Medical Practice Act, which provided that a “certificate of midwifery authorized the holder to attend cases of normal childbirth,” and § 2141 of the same Act, which provided:

Any person, who practises or attempts to practice, or who advertises or holds himself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes
for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other mental or physical condition of any person, without having at the time of so doing a valid, unrevoked certificate as provided in this chapter, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a misdemeanor. 262

The three charged women cited numerous court decisions characterizing childbirth as a normal biological function of women, rather than a "disease or sickness" in support of their argument that their attendance in home deliveries did not constitute the practice of medicine. 263 However, the Supreme Court of California relied on the phrase "physical condition" and argued that such phrase does not necessarily imply the existence of an abnormality or disease and, therefore, readily encompasses pregnancy and childbirth. 264 The Supreme Court of California held that although pregnancy is not a "sickness or affliction," pregnancy is a "physical condition." The Court then concluded that the Code prohibits unlicensed persons, including the three lay midwives from Santa Cruz, from diagnosing, treating, operating upon, or prescribing for a women undergoing normal pregnancy or childbirth and that such activities only may be undertaken by certified nurse-midwives. 265

The Supreme Court of California also addressed the three lay midwives' arguments that the California Medical Practice Act provisions were unconstitutionally overbroad and violated a pregnant woman's right of privacy to choose a lay midwife to attend a home delivery. The Court ruled that although the phrase "other mental or physical condition," read in the context of the entire paragraph, was "admittedly broad," it was not "overbroad," especially in light of the State's "strong and demonstrable interest in protecting its citizens from persons who claim some expertise in the healing arts but whose qualifications have not been established by the receipt of a certificate." 266 With respect to the privacy claim, the Court explained, rather defensively, that:

For the same policy reasons for which the Legislature may prohibit the abortion of unborn children who have reached the point of viability, it may require that those who assist in childbirth have valid licenses. Its interest in regulating the qualifications of those who hold themselves out as childbirth attenders is an equally strong one, for many women must necessarily rely on those with qualifications which they cannot personally verify. Not is the state's interest in requiring a license diminished by the fact that childbirth with assistance, even the assistance of an unlicensed person, may be safer than self-delivery. The state need not prohibit the most unlikely of

262 CAL. BUS. & PROF. CODE § 2141 (Deering 1976) (emphasis added).
263 Id. at 1084.
264 Id.
265 Id.
266 Id. at 1088.
circumstances—childbirth without assistance—in order to justify regulating the much more common event—assistance of the mother at childbirth. In the area of public welfare, the Legislature need not attack every social problem at once. Plaintiffs’ further arguments as to the safety of home deliveries are more properly addressed to the Legislature than the courts, particularly since the Legislature, by its recent enactments pertaining to midwifery... [in 1975], has shown continuing interest in the area.  

Eleven years later after the California Supreme Court issued its decision in Bowland, a California Court of Appeals reviewed a somewhat similar set of facts in Northrup v. Superior Court. In Northrup, Geneva Northrup and Julia Young, who were members of The Church of the First Born, applied for a writ of prohibition requesting that charges brought against them for practicing midwifery without proper certification be set aside. Under the tenets of The Church of the First Born, use of medical professionals is not permitted. Pregnant members of the Church do not consult obstetricians. Instead, they use attendants like Northrup and Young, who are also Church members, to assist them at childbirth.

Three births formed the basis of the charges in the instant decision. On December 29, 1984, Northrup and Young attended the labor of Pat Bell, Northrup’s daughter. Pat’s daughter was stillborn. On January 5, 1985, petitioner Northrup attended the delivery of Frieda Wilkinson, whose daughter was born healthy. Finally, on April 26, 1985, Northrup attended the delivery of her daughter-in-law, whose baby boy was stillborn.

The Court of Appeals ultimately held that although the activities of the attendants constituted midwifery and the treatment of a “physical condition” under the California Medical Practice Act, per Bowland, the attendants were exempt from the midwifery certification pursuant to a religious practice exemption in light of the fact that they were attending the deliveries of other members of their Church.

C. The California Licensed Midwifery Practice Act of 1993

In 1982, the Department of Consumer Affairs issued a report stating that both lay and nurse midwives provided perinatal services proven to lower perinatal morbidity and mortality rates. The California Legislature was persuaded by that report and, in 1993, enacted the California Licensed Midwifery Practice Act of

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267 Id. at 1089.  
268 Northrup, 237 Cal. Rptr. at 255.  
269 Id. at 256.  
270 Id. at 257.  
271 Id.  
272 The California Medical Practice Act’s religious practice exemption provided, in relevant part: “Nothing in this chapter shall be construed so as to . . . regulate, prohibit, or apply to any kind of treatment by prayer, nor interfere in any way with the practice of religion.” CAL. BUS. & PROF. CODE § 2063 (Deering 2004).  
273 Northrup, 237 Cal. Rptr. at 258-59.  
274 See also 1993 Cal. Stat. ch. 1280, § 1(h), (referring to the 1982 report and noting the report’s influence on the California Legislature).
1993 (CLMPA)\textsuperscript{275} to help facilitate pregnant women's access to lay midwife-attended home births. Importantly the CLMPA governed both lay and nurse midwives, unlike the California Legislature's 1917, 1937, 1949, and 1975 enactments. Thus, one effect of the legislation was to professionalize lay midwifery in the State of California.\textsuperscript{276}

The CLMPA establishes the scope of practice of a licensed midwife and permits midwives to attend home deliveries if such midwives work under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics:

(a) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.\textsuperscript{277}

The CLMPA further explained that the term "supervision" should not be construed to require the physical presence of the supervising physician and surgeon.\textsuperscript{278}

Following the passage of the CLMPA, many medical malpractice carriers discontinued coverage of, or dramatically increased premiums for, those physicians who supervised midwives under the CLMPA.\textsuperscript{279} Accordingly, few midwives have established the required relationship with a physician to enable them to attend home deliveries in strict compliance with the CLMPA.\textsuperscript{280} Through 2001, 111 midwives became licensed in California under the CLMPA. However, as of 2001, only one midwife was able to obtain a supervising physician. That midwife also happened to be licensed under California law as a physician's assistant, perhaps explaining her physician's trust.\textsuperscript{281} Because of physicians' reluctance to serve as supervising physicians, the CLMPA's supervision requirement has been referred to as an "unintended legal barrier which has rendered the legislation unworkable and

\textsuperscript{275} CAL. BUS. & PROF. CODE §§ 2505-08, 2511-2515.5, 2517-2521 (Deering 2004).
\textsuperscript{276} Until the CLMPA, only physician assistants and registered nurses could, within the scope of their respective license practice acts, obtain additional licensure as midwives.
\textsuperscript{277} CAL. BUS. & PROF. CODE § 2507(a), (b) (Deering 2004).
\textsuperscript{278} Id. § 2507(c).
\textsuperscript{279} See Happe, supra note 66, at 713 & n.4.
\textsuperscript{280} Id. at 714 & n.5.
\textsuperscript{281} Id. at 722 & n.79.
 unusable for California women and families."  

D. Administrative Scrutiny and Criminal Prosecution of Midwives

Some midwives who were unable to secure a supervising physician as required under the CLMPA continued to attend home deliveries, but not without scrutiny from the Medical Board of California. Indeed, from August 16 to 20, 1999, an Administrative Law Judge in Sacramento heard In re Osborn, an administrative action taken by the California Medical Board to determine whether a woman’s license to practice midwifery should be revoked. The respondent, Alison Osborn, was a lay midwife who was properly licensed under the CLMPA. Unfortunately, Osborn lived and worked in an area in which the obstetricians were very hostile to licensed midwives, and Osborn had been unable to find a physician who would agree to formally supervise her. Nevertheless, Osborn was able to find a physician who agreed to provide informal collaborative consultations as well as assistance with respect to emergent issues.

When one of her patients delivered a stillborn during a breech birth, Osborn’s situation came to the attention of the Medical Board of California. However, the Medical Board decided not to revoke Osborn’s license, recognizing that, “No California physician [will] supervise licensed midwives who undertake home births for reasons related primarily to liability exposure” and that “a small minority of California physicians object to licensed midwives and will not undertake their supervision on philosophical grounds.” The Medical Board further found that Osborn had demonstrated her experience, competency, devotion, dedication, concern, and professionalism for both midwifery and patients during the hearing. The Medical Board concluded that a licensed midwife who possesses a relationship (albeit an informal one) with a California physician and surgeon as referenced in the CLMPA “has feasibly and reasonably satisfied the ambit of the Act”:

In an effort to practice their art, virtually all of California’s 109 licensed midwives, including Respondent, have, with the cooperation of physicians sympathetic to their plight and who seek to expand the options available to patients, developed a relationship that involves collegial referral and assistance, collaboration, and emergent assistance without direct or accountable physician and surgeon supervision of licensed midwives. In an effort to promote the efficacy of the Act, this tribunal concludes, at this time, that a licensed midwife who possesses a relationship with a California physician and surgeon as referenced herein has feasibly and reasonably satisfied the ambit of the Act. Accordingly, cause does not exist.

282 Id. at 714 & n.5.
284 Id.
285 Id.
to revoke or suspend the license of Respondent pursuant to Business and Professions Code section 2519(e), in conjunction with sections 2507(a) and 2507(b), for unprofessional conduct arising from lack of supervision as set forth in Findings 13-14 and 17-23.286

The State of California did not charge Osmond with a violation of a criminal provision. However, early in 2000, the State of California did charge Lori Jensen, a lay midwife practicing in Orange County, with contributing to the death of an infant by illegally injecting the laboring mother with Pitocin, a labor inducing drug.287 The use of the drug violated the CLMPA provision prohibiting midwives from using artificial or forcible means to assist childbirth.288 When Jensen pled guilty to contributing to the death of the infant, California obtained its first successful criminal prosecution of a licensed midwife in the state.289

E. Legislative Attempts to Eliminate the Physician Supervision Requirement for Licensed Midwives

In 2000, the California Legislature introduced a new statute that would have eliminated the physician supervision requirement for licensed midwives [hereinafter 2000 Legislation].290 The introduced version would have redefined the relationship between the licensed midwife and the physician as “consultative,” reasoning that removing the supervision requirement would “remove a barrier for physicians who wish to consult with licensed midwives and increase the quality and safety of the care for both the mother and the baby.”291 However, the introduced version eventually was amended in committee to require the continuance of the supervision requirement.292

Although the supervision requirement was continued, the 2000 legislation contained statements of important findings regarding the benefits of midwifery, an acknowledgement that childbirth is a natural process, and a statement that a woman has the right to choose her birth setting from those safely available to her.293 The

286 Id.
287 See Judy Silber & Richard Marosi, O.C. Midwife's Actions Contributed to Death of Baby, Officials Say; Prosecutors Charge Her with Breaking the Law By Giving a Drug without a Doctor's Supervision, Her Lawyer Says She Is Not Guilty, L.A. TIMES, Apr. 23, 2000, at B1.
288 See CAL. BUS. & PROF. CODE § 2507(b) (Deering 2004).
291 See California Senate Rules Committee, Senate Analysis of SB 1479, at 4 (April 6, 2000); and SB 1479 Midwifery Fact Sheet from Senator Liz Figueroa 3 (undated) (asserting that changing the midwife-physician relationship from one of supervision to one of consultation would cause physicians to feel “more free to communicate with midwives” and provide patients with “optimal health care in the home environment”).
293 Id. Additional findings included a description of the midwifery model of care as one that emphasizes informed consent and support throughout the birthing process, an assertion that studies support the safety of midwifery care for low-risk women, and a statement that midwife-assisted home birth is an important option for women. Id. § 4(c)-(e).
2000 Legislation stated that "[n]umerous studies have associated professional midwifery care with safety, good outcomes, and cost effectiveness in the United States and other countries."\textsuperscript{294} In addition, the 2000 Legislation specifically rejected the California Supreme Court's decision in Bowland by stating that "[e]very woman has a right to choose her birth setting from the full range of safe options available in her community" and that "[t]he midwifery model of care is an important option within comprehensive health care for women and their families and should be a choice made available to all women who are appropriate for and interested in home birth."\textsuperscript{295} Those who viewed Bowland's rejection of the lay midwives' constitutional right of privacy claims as "scandalous"\textsuperscript{296} likely were pleased by the specific findings set forth within the 2000 Legislation.

The 2000 Legislation also required midwives to disclose specific information to their patients in order to ensure that the patients were giving their informed consent to attendance by a midwife. The information to be disclosed orally and in writing included the type of practice authorized by the midwife's license, the definition and scope of midwifery, the definition of "supervision," the permitted ratio of midwives to supervising physicians, those activities in which midwives are not permitted to engage, a statement regarding whether the midwife carries liability insurance, specific arrangements the midwife has made for transfer of care in case of emergency, and a statement regarding how patients may report complaints to the Medical Board of California.\textsuperscript{297} The midwife's written disclosure had to be signed by the midwife and the client and a copy of the disclosure had to be placed in the patient's medical records.\textsuperscript{298} Although the 2000 Legislation did not formally remove the physician supervision requirement, the Legislation dispensed with the requirement that midwives had to disclose the name of a specific physician who would be updated on the case and take over care in the case of an emergency.\textsuperscript{299}

VI. CONCLUSION

Historians have analyzed and interpreted birth statistics, medical textbooks, minutes of medical society meetings, public health reports and many, many other sources to identify the direct and indirect roles played by professional and economic competition, class, race, and gender in physicians' opposition to midwives and the transition in the United States from lay midwife-assisted home births to physician-assisted hospital births. Parts III, IV, and V of this article

\textsuperscript{294} Id. § 4(d). The 2000 Legislation also includes the following specific findings: "California studies suggest that low-risk women who choose a natural childbirth approach in an out-of-hospital setting will experience as low a perinatal mortality as low-risk women who choose a hospital birth under management of an obstetrician, including unfavorable results for transfer from the home to the hospital." Id. § 4(d).

\textsuperscript{295} Id. § 4(b), (e).

\textsuperscript{296} Happe, supra note 66, at 726.

\textsuperscript{297} CAL. BUS. & PROF. CODE §§ 2507(b)-(e), 2508(a)(2)-(4) (Deering 2004).

\textsuperscript{298} Id. § 2508(b).

\textsuperscript{299} Id. § 2508(a)(3).
identify and discuss an additional source of material: the texts of Alabama, Massachusetts, and California judicial opinions interpreting state regulation of lay midwifery practices. In light of these texts, this Part VI addresses the following questions: Why did the courts consistently defer to legislative findings that high infant and maternal mortality rates justified stringent regulation of midwives? Why did the courts continue to uphold statutory requirements for physician supervision of midwives and statutes that restrict the practice of lay midwifery?

A. Judicial Deference to Legislative and Physician Conclusions Regarding Public Health

A plain reading of the judicial opinions issued by the courts in Alabama, Massachusetts, and California would appear to perpetuate the argument that the practice of lay midwifery is unsafe, that midwives lack education and knowledge, and that state restriction of lay midwifery was and is necessary to improve the health of mothers and infants.

For example, in *State v. Kimpel*, the State of Alabama charged Toni Darlene Kimpel in five separate indictments of practicing nurse midwifery without a license in violation of Alabama's Act 499.300 Importantly, the court specifically rationalized Act 499's effective ban on the practice of lay midwifery by stating that the "protection of the safety of a mother and child during labor and delivery is a legitimate government objective."301 For more than one hundred years, the "phasing out of traditional southern black midwives was said to be the key to lowering high infant mortality rates."302 Although infant mortality in Greene County, Alabama was admittedly high, the rate of mortality did not consistently correlate with percentages of midwife attended births.303 Indeed, Alice Forman, who worked with Mrs. Smith in one of the public health clinics, noted that the high mortality rates persisted even when the midwives attended few deliveries.304 Importantly, however, the *Kimpel* court fails to mention any of the public health studies, including studies like those published in the *Alabama Medical Journal*, concluding that the "colored rate is lower than the white rate in maternal mortality by 9 percent and neonatality by 35 percent,"305 thus suggesting a lack of association between the lay midwives who delivered the majority of the black population's babies and maternal and infant mortality. In summary, the *Kimpel* court simply deferred to the Alabama Legislature's general finding that public health required the elimination of the lay midwife without any serious analysis regarding whether the public health truly was threatened by lay midwifery practices.

300 *Kimpel*, 665 So.2d at 991.
301 *Id.* at 994.
302 SMITH & HOLMES, supra note 1, at 140.
303 *Id.* at 141-42.
304 *Id.* at 141-42.
305 *Id.* at 65-66.
In addition, the *Kimpel* court either negligently misunderstood, or intentionally misrepresented, the reason for the demise of the Alabama midwife. The *Kimpel* court explains that "[a]ll those [midwives] who previously held the permits have terminated their practice," thus suggesting that the midwives themselves ended their practices because the practice of midwifery was no longer viable or clients were difficult to come by. However, Alabama midwives did not voluntarily cease their practices; instead, public health officials refused to renew their permits and directed each remaining lay midwife, by letter or in person, to discontinue her practice.

In summary, the *Kimpel* court defers to both the Alabama Legislature's general, but perhaps unsupported, conclusions regarding the association between lay midwives and maternal and infant mortality and the need for regulation without carefully scrutinizing the situation or noting studies that support the contrary view and misrepresents the way in which midwives' practices were terminated.

Similarly, in the 1907 prosecution of Massachusetts midwife Hanna Porn, the Supreme Judicial Court of Massachusetts deferred to the testimony of physicians who testified on behalf of the Massachusetts Board of Registration in Medicine, as well as to "medical and popular lexicographers," in adopting a theory that the practice of midwifery was the same as the practice of obstetrics. Similarly, in the 1985 administrative action against registered nurse Janet Leigh in *Leigh v. Board of Registration*, the Supreme Judicial Court of Massachusetts summarily responded to several of Leigh's arguments with a statement that the 1975 legislation banning home deliveries by nurses bore a "reasonable and substantial relation to the public health, safety, morals, or some other phase of the general welfare." Similar to the Alabama court in *Kimpel*, the *Leigh* court also failed to note studies showing, for example, that infants born in midwife Hanna Porn's attendance were twice as likely to survive as infants born in the attendance of physicians.

In summary, the *Leigh* court simply deferred to the Massachusetts' Legislature's "preference that births attended by nonphysicians take place in licensed facilities. . . ."

Likewise, in the Supreme Court of California's *Bowlard* decision, three midwives from the Santa Cruz Birth Center were charged with the unlicensed practice of medicine. The Supreme Court of California also deferred to the California Legislature's conclusions that California residents need to be protected "from persons who claim some experience in the healing arts but whose

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306 Emphasis added.
307 SMITH & HOLMES, supra note 1, at 134-35.
308 Porn, 82 N.E. at 31.
309 *Leigh*, 481 N.E.2d at 1354 (quoting Sperry & Hutchinson Co. v. Director of the Div. on the Necessaries of Life, 307 Mass. 408, 418 (Mass. 1940)).
310 Corcoran, supra note 66, at 649.
311 *Leigh II*, 506 N.E.2d at 93.
312 *Bowlard*, 556 P.2d at 1081.
qualifications have not been established by the receipt of a certificate.” Like the other courts discussed in the preceding paragraphs, the Supreme Court of California did not scrutinize the Legislature’s general conclusions despite statistics available to it that would suggest the contrary.

In summary, the Alabama, Massachusetts, and California judicial opinions perpetuate the argument that the practice of lay midwifery is unsafe, that midwives lack education and knowledge, and that state restriction of lay midwifery is necessary to improve the health of mothers and infants. The judicial opinions perpetuated this argument by deferring to the legislatures’ and physicians’ somewhat unsupported conclusions regarding regulation that was needed to improve the health of the public without engaging in any type of analysis to determine whether such regulation was needed.

In light of this information, one issue that arises is whether the legislatures’ and physicians’ attempts to eliminate midwifery through administrative disciplinary action and criminal prosecution were based solely on their beliefs that midwifery was unsafe or, instead, were they motivated by other, more important, factors.

B. The Force of Economic Competition

A review of the case law discussed in Parts III, IV, and V suggests that physicians’ and legislatures’ focus on the need to eliminate lay midwifery to improve the public health may be a disguised objection to the economic competition of midwives.

For example, Part III shows that in the early twentieth-century, many Alabama physicians did not object to sharing the childbirth work with midwives, especially since many of the poorer patients served by the midwives did not even have the money to pay for the lower-cost midwife-attended deliveries. Indeed, most of Mrs. Smith’s patients were poor, black women, many of whom could not and did not pay Mrs. Smith for her midwifery services. Her competitor physicians thus had no incentive to struggle for these non-paying clients. However, when Mrs. Smith obtained a permit to attend deliveries of public health clinic patients, her fees were established and easier to collect. As discussed in Part III, once the midwives’ fees increased to fifty dollars per delivery, the medical establishment increased its efforts to terminate their practices: “When it got on up there to fifty, that’s when they wanted the midwives off.”

Similarly, in Alabama’s Kimpel decision, the Mobile County indictments

313 Id. at 1088.
314 See supra Part II.
315 SMITH & HOLMES, supra note 1, at 65.
316 Id. at 75.
317 Id. at 76-77.
stressed the fact that the defendant midwife received “payment or other consideration” in exchange for her midwifery services even though the receipt of remuneration was not an element of an Act 499 violation.318

Moreover, in Massachusetts, economic competition also seemed to play an important role in the strong opposition of the early twentieth-century physicians and legislatures (and, hence, deferential judiciary) to the local midwives. In Commonwealth v. Porn, it becomes apparent that cost was likely an important factor in midwife Hanna Porn’s clients’ decision to use her.319 Porn only charged between two and five dollars for an entire array of midwifery and nursing services, whereas the local physicians charged three times that amount.320 Again, although establishing receipt of remuneration by a midwife was not a required element to prove a violation of Massachusetts’ 1894 Medical Practice Act, the Board of Registration in Medicine emphasized that “Porn delivered many women in childbirth for compensation...”321 thus suggesting the Board’s concern for the amount of money she earned practicing midwifery.

Likewise, the Lawrence, Massachusetts, midwives who practiced in the early twentieth-century also charged only five dollars for a similarly wide array of midwifery and nursing services, and would accept payment of food and services as “in kind” payments.322 However, the local Lawrence physicians’ going rate was ten dollars, and they wanted their money in cash, not “in kind.”323

Moreover, the defendant midwife in Leigh argued that the 1975 Massachusetts legislation banning home deliveries illegally restrained trade in violation of federal and Massachusetts antitrust law.324 Stated another way, the defendant midwife’s argument was that the Massachusetts legislation created a physician monopoly over the available childbirth work. However, the Leigh court summarily dismissed the midwife’s claims, simply stating that the actions of both the Massachusetts Legislature and, important to the instant decision, the Massachusetts Board of Registration in Medicine, were exempt from antitrust liability because they were entitled to sovereign immunity.325 The Leigh court’s entitlement of sovereign immunity to the Board of Registration in Medicine, which is composed of many physicians, demonstrates the power and influence held by the Massachusetts medical establishment.

In conclusion, the Alabama and Massachusetts courts appear to emphasize both the defendant midwives’ receipt of remuneration (even when receipt of such remuneration was not an element necessary to prove a statutory violation) and the

318 Kimpel, 665 So.2d at 993.
319 Corcoran, supra note 66, at 649.
320 Id.
321 Porn, 82 N.E. at 31.
322 Declercq & Lacroix, supra note 5, at 387.
323 Id.
324 Leigh II, 506 N.E.2d at 94-95.
325 Id. at 95.
midwives' competitive fee schedules. Perhaps the defendant midwives' competitive pricing provides one explanation for local physicians' strong opposition to midwifery practices. Stated alternatively, if informally trained midwives were capable of delivering children safely (and sometimes even more safely than local physicians) and for a significantly reduced fee, then perhaps the local physicians were concerned because the midwives threatened the physicians' efforts to earn high fees and professionalize obstetrics. Joseph B. De Lee, the prominent nineteenth-century obstetrician, complained about this very possibility: "[A]s long as the medical profession tolerates that brand of infamy, the midwife, the public will not be brought to realize that there is high art in obstetrics and that it must pay as well for it as surgery."326

Indeed:

In 1990, the U.S. Department of Health and Human Services reported that "female with delivery" was the most common hospital discharge category. Since hospital birth is a major source of revenue for most public and private hospitals, it is understandable that hospital associations join with physicians to lobby against out-of-hospital births.327

C. The Force of Professional Competition

This section discusses the professional, or status, competition that existed between physicians and midwives. In many of the decisions discussed in Parts III, IV, and V, the defendant midwives unsuccessfully argued that the application of the restrictive midwifery regulations resulted in violations of their right to equal protection under the laws. For example, in Alabama's Kimpel decision, Ms. Kimpel's third and final challenge to her indictment was that Act 499 violated her right to equal protection under the law.328 However, the court responded by asserting that the right to choose a profession is only governed by the low rational basis standard of review and, therefore, since the State of Alabama offered a rational explanation for its legislation—that the protection of the safety of a mother and child during labor was a legitimate government objective—the legislation must be upheld.329

Similarly, in Massachusetts' Commonwealth v. Porn decision, defendant midwife Hanna Porn also argued that the 1894 Medical Practice Act's midwifery ban was unconstitutional as legislation that had a disparate impact on midwives as a profession.330 In response, the court summarily stated that, "[the statute's] validity cannot be questioned on this ground. The maintenance of a high standard of professional qualifications for physicians is of vital concern to the public health,

327 Suarez, supra note 16 at 321-22.
328 Kimpel, 665 So.2d at 994.
329 Id.
330 Porn, 82 N.E. at 31.
and reasonable regulations to this end do not contravene any provision of the state or federal Constitution."\textsuperscript{331} Here, the Massachusetts Supreme Judicial Court's concern with maintaining the high status of the medical profession, vis-à-vis the status of the midwifery profession, is evident. Moreover, in Leigh (another Massachusetts' opinion), the defendant midwife Janet Leigh also argued a violation of her right to equal protection and the court summarily responded that "[t]he Legislature has expressed its preferences that births attended by nonphysicians take place in licensed facilities with the assistance of certified nurse midwives..."\textsuperscript{332}

Finally, in the California administrative decision, \textit{In re Osborn}, the Administrative Law Judge, although not requiring strict adherence to California's physician supervision requirement, did perpetuate the requirement that midwives obtain physician collaboration in their practices.\textsuperscript{333} Accordingly, \textit{In re Osborn} subordinates California's "professionalized" licensed lay midwives to the physicians with whom they are required to consult and collaborate.\textsuperscript{334} To the extent a particular midwife is unable to find a collaborating physician, she will be unable to practice midwifery legally in California.\textsuperscript{335} Thus, physicians can place midwives in a subordinate position in the health care professional hierarchy by refusing to collaborate with them or by collaborating with them but controlling the way in which they practice. One could interpret the physician supervision requirement as one way in which the California medical establishment continues to belittle midwives' training, experience, and expertise. Finally, the 2000 California legislation requires midwives to disclose substantially more information to their patients than obstetricians are required to disclose in similar circumstances,\textsuperscript{336} which could be interpreted as giving obstetricians an unfair competitive advantage compared to midwives.

In summary, the Massachusetts, Alabama, and California legislation and judicial opinions discussed above appear to favor the continued professionalization and establishment of higher standards for physician obstetrics, while opposing the professionalization of midwifery. One of the most direct statements opposing the professionalization and "legal status" of midwifery was made by obstetrician Charles Ziegler:

My own feeling is that the great danger lies in the possibility of attempting to educate the midwife and in licensing her to practice midwifery, giving her thereby a legal status which later cannot perhaps be altered. If she once become a fixed element in our social and economic system, as she now is in the British Isles and on the Continent, we may never be able to get rid of

\textsuperscript{331} \textit{Id.} (emphasis added).
\textsuperscript{332} \textit{Leigh II}, 506 N.E.2d at 93.
\textsuperscript{333} \textit{In re Osborn}, \textit{supra} note 283.
\textsuperscript{334} \textit{Id.}
\textsuperscript{335} \textit{Id.}
\textsuperscript{336} \textit{CAL. BUS. \\& PROF. CODE} §§ 2507(b)-(e), 2508(a)(2)-(4) (Deering 2004).
D. Issues of Class and Race

Although not specifically identified by the Alabama, Massachusetts, or California courts, class and racial issues may have played a role in the judiciaries’ continued deference to midwifery practice restrictions. The Kimpel court’s failure to note the disparate impact of Alabama Act 499 on the 150 remaining practicing midwives, all of whom were black, is significant. Had Kimpel’s attorneys properly identified and argued Act 499’s impact on a suspect class and persuaded the court to apply the more stringent strict scrutiny level of review, the outcome of the case may have been different.

Similarly, although not specifically stated in Commonwealth v. Porn, it is significant that Gardner, Massachusetts midwife Hanna Porn was born in Finland and that almost all of Porn’s clients were working class women from Finnish, Russian, and Swedish communities. The Italian surnames of the three prominent Lawrence, Massachusetts, midwives (Pedrazzini, DeMarco, and Carpenito) suggests their immigrant status as well.

Perhaps midwifery’s demise in Alabama and Massachusetts was due in part to shifting social attitudes regarding race and class, instead of true concern regarding the health of the public. Perhaps black and immigrant midwives became an easy target for white upper-class physicians who were unable to support their opposition to midwifery with sound public health arguments. Instead, physicians may have found it easier to support their propositions by using the prevalent stereotype of the dirty and ignorant midwife and emphasizing the unhealthy living environments in which many low income black and immigrant families lived.

As discussed in Part II, white Alabama physicians in the 1940’s directed specific campaigns towards white women in an attempt to persuade them not to have their births be attended by black midwives, despite many white women’s respect for the skills of their black midwives. Similarly, through aggressive campaigns and journal articles, the American Medical Association attempted to convince the public that midwives were “backward, dirty, ignorant, and incapable of handling an event that was viewed as rarely normal and always fraught [sic] with danger.”

338 Corcoran, supra note 66, at 649.
339 See Declercq & Lacroix, supra note 5, at 383.
340 Lowis & McCaffery, supra note 60, at 23.
341 Id. at 21, 67.
342 LITOFF, supra note 5, at 429.
E. Gender Issues

The Alabama, Massachusetts, and California opinions discussed in Parts III, IV, and V do not directly suggest that gender played a role in the demise of midwifery in those states. However, one could argue that the independent practice of midwifery ran contrary to late nineteenth century views relating to the appropriate domestic role, and passive character, of women. Midwifery required the midwife to leave her home and apply her experience to a constantly changing, potentially dangerous, and probably exciting environment. As demonstrated by Maine midwife Martha Ballard and, to an extent, by Mrs. Smith, Hanna Porn, and the Lawrence, Massachusetts, midwives, a successful midwifery practice was one way for women to obtain financial independence and intellectual satisfaction.343 Interestingly, when Act 499 effectively ended the legal practice of lay midwifery in Alabama, Mrs. Smith was forced to accept work as a live-in nurse, taking care of white infants in their homes.344 Although nursing jobs with well-to-do white families provided more money than delivering babies to poor black women in Alabama, Mrs. Smith characterized such work as submissive and domestic compared to her independent midwifery practice.345

In addition, and although not specifically stated by the Alabama, Massachusetts, and California courts, the courts’ continual refusal to acknowledge the skills of the defendant women midwives and their positive health outcomes suggests that the women midwives’ experiential knowledge was both subordinate to the male physician’s new scientific knowledge and rejected as a means of establishing professional and legal standing.346

In conclusion, an analysis of the texts of Alabama, Massachusetts, and California judicial opinions demonstrates that a confluence of professional, economic, class, race, and gender forces may have played a role in the judiciaries’ continued deference to state legislative preferences for physician-controlled childbirth and stringent regulation of midwives.

343 See SMITH & HOLMES, supra note 1; Porn, 82 N.E. at 31; Declercq & Lacroix, supra note 5, at 383.
344 SMITH & HOLMES, supra note 1, at 146.
345 Id. at 121.
346 LAY, supra note 67, 172-73.