A Matter of the Quality of Birth: Mothers and Midwives Shackled by the Medical Establishment and Pennsylvania Law

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I. INTRODUCTION

The various social and political protest movements of the last two decades have continued the tradition of awakening widespread sensitivity to individual freedoms and the need for their preservation. Those of childbearing age are beginning to question why even the process of birth is subject to state control. The criminalization or strait jacket regulation of midwifery has had the effect of severely limiting choice of birth setting and birth attendant in many states.

Using the laws of the Commonwealth of Pennsylvania as a backdrop, this comment will draw the jurisprudence of midwifery into focus. The history of obstetrical practices, the development of legislation and case law inimical to the practice of midwifery, and a delineation of the alternative birth controversy and issues have been explored elsewhere. With such a foundation, this comment

1. A sampling of the works about birthing and related issues which have proliferated in the last decade indicates that the women's movement and the natural childbirth movement are, in part, responsible for an increasing challenge to the standard interventionist practice of obstetrics developed in this nation since World War I. See Y. Brackbill, J. Rice & D. Young, Birth Trap (1984) [hereinafter cited as Brackbill & Young]; J. Isaacs Ashford, The Whole Birth Catalog (1983); E. Davis, A Guide to Midwifery (1981); A. Gilgoff, Home Birth (1978); L. Gordon, Woman's Body, Woman's Right (1976); S. Arms, Immaculate Deception (1975).

2. 63 Pa. Cons. Stat. §§ 171-76 (1984); 49 Pa. Code §§ 17.121-.168 (1978); and 55 Pa. Code §§ 1142.1-.81 (1984) relate specifically to midwifery. They are the only pronouncements by the state legislature readily accessible to the public concerning the practice of attending women in childbirth by anyone other than a regularly licensed physician or osteopath. The statute was enacted in 1929, and provides for certification by the State Board of Medical Education and Licensure and for criminal penalties in the absence of certification. See infra notes 59-90 and accompanying text. The regulations in title 49 of the Pa. Code concern supervision of midwives and the scope of their activities. They require applicants to be licensed registered nurses. The latter regulation, signed into law by the governor in 1982, provides for direct payments to duly certified midwives under the Medical Assistance Program.

3. See Caldwell, Bowland v. Municipal Court Revisited: A Defense Perspective on Unlicensed Midwife Practice in California, 15 Pac. L. J. 19 (1983) (reassessing the refusal by the California Supreme Court to recognize that birth should fall under the right to pri-
will expand the medical underpinnings to the controversy and suggest future legal strategies relating to midwives and their practice in Pennsylvania.

Modern medical technologies in tandem with healthier, better-informed women have made important contributions to improved outcomes for mothers and their newborn infants since the turn of the century. Technology run rampant, however, may be responsible for this nation's lagging performance with respect to infant and maternal mortality rates. The routine use and misuse of equipment, drugs and procedures by medical professionals during labor and delivery have been linked as well to potentially avoidable physical malformations, mental dysfunction, behavioral problems, and child abuse. Additional contraindications to current high-tech
birth practices include the high prices charged for obstetrical services, the resort to technology primarily because the field is rife with malpractice actions, and the traditional lack of access to good prenatal care by the poor.

developing during labor, at extreme risk of impairment) [hereinafter cited as Prescription Drugs Hearing]; Examination of obstetrical practices such as the use of fetal monitors, the increasing rate of cesarean sections, elective induction of labor and the use of drugs in pregnancy and labor: Hearing Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources, 95th Cong., 2d Sess. 130 (1978) (statement of Yvonne Brackbill, Ph.D., Prof. of Psychology, U. of Fla.) (finding that there are statistically significant behavioral effects of obstetric medication including behavioral degradation and IQ loss which are related to drug use and potency) [hereinafter cited as Obstetrical Practices Hearing]; and ARMS, supra note 1, at 135-39 (describing the studies conducted by Marshall Klaus on mother-infant separation which suggest that the battered child syndrome may be an ultimate effect of this usual hospital practice following birth). But see INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, RESEARCH ISSUES IN THE ASSESSMENT OF BIRTH SETTINGS, REPORT OF A STUDY BY THE COMMITTEE ON ASSESSING ALTERNATIVE BIRTH SETTINGS 7 (1982) (stating that the safety of different birth settings and the practices unique to each cannot be presently determined because of lack of reliable information) [hereinafter cited as BIRTH SETTINGS]; Prescription Drugs Hearing, supra at 150-54 (testimony of Kenneth Ryan, M.D., Chairman, Dep't of Obstetrics and Gynecology, Harv. Med. Sch.) disagreeing with testimony of Doris Haire that a great percentage of the four million children in this country with dysfunctions are victims of the drugs administered to their mothers during labor and delivery, but stating that doctors should be discouraging any drug use at that time where the use is discretionary given the fact that the cause of most malformations is unknown).

7. See BRACKBILL & YOUNG, supra note 1, at 55, for a comparison of the cost encountered in birth centers, ranging from $200 to $1700, with average hospital charges ranging from $550 to $3750. The latter figures do not include possible intensive care costs for the infant which can go as high as $15,000. Id. at 27.

8. See Obstetrical Practices Hearing, supra note 6, at 187 (testimony of Ervin D. Nichols, M.D., Director, Practices Activities, Am. C. of Obstetricians and Gynecologists) (stating that the use of fetal heart monitors is intimately linked to malpractice suits); BRACKBILL & YOUNG, supra note 1, at 94 (noting that malpractice litigation is increasing, especially in obstetrics).

The basis of a malpractice action is negligence, and the standard of care among professionals is the legal measurement of that negligence. As more and more physicians utilize technological innovations in their practice, such utilization becomes the underlying basis for the medical standard of care. Hence, those using certain drugs, procedures or equipment do so regardless of medical indication, believing that they can thereby avoid a finding of negligence. Id. at 30-31.

9. See Robin, A Right to the Tree of Life, 238 NATION 698 (June 9, 1984), which reports the abysmal mortality statistics for black infants, 20 deaths per 1,000 births in 1981, which is twice the rate of deaths among white infants before their first birthday, due, primarily, to lower birth weights which are the result of a lack of prenatal care. The high price tags which accompany obstetric services certainly prevent many women from receiving proper care, see supra note 7, and many women simply do not know that prenatal care is essential to ensure good outcome. See Oversight Hearing, supra note 4, at 2-3 (opening remarks of Senator Alan Cranston) (recognizing that improving accessibility of low income women to health care services and improving health education programs could reduce infant deaths and disabilities).
Properly qualified midwives can provide the antidote to many of these and other dilemmas associated with unnecessary medical intervention in the majority of low risk childbirths.\textsuperscript{10} Hence, interested consumers, health practitioners, and federal and state governments are reassessing current obstetrical practices in light of cost, safety, effectiveness and the laws which impede consumer choice of birth attendant.\textsuperscript{11}

The jurisprudence of midwifery is comprised of many and varied elements, not all of them adverse to practicing midwives. Doctors who lock their colleagues out of medical facilities because they provide back-up to midwives are being challenged for antitrust violations.\textsuperscript{12} Insurance plans that do not provide for payments to mid-

\textsuperscript{10} Essentially, there are two different types of midwives practicing today, certified nurse-midwives who must undergo the usual nursing education with further instruction in this specialized area, and lay midwives who train themselves through apprenticeship, book study, and sometimes by way of matriculation from one of the few midwifery schools in the nation. See Evenson, \textit{supra} note 3, at 314. Lay midwives generally work beyond the limits of legality, particularly in states such as Pennsylvania where such practice is punishable by fine and/or imprisonment. See \textit{supra} note 2. It is believed that lay midwives do not seek legitimization via the training required by law because they cannot afford it or because they reject the pathological emphasis on childbirth inculcated by the medical establishment. See Sallomi, Pallow-Fleury \& O'Mara McMahon, \textit{Midwifery and the Law} (1983); Interview with Ellen Gaefke, Certified Professional Childbirth Educator, Association for Childbirth at Home International of Southwest Pennsylvania (June 25, 1984). This comment includes both kinds of midwives under the rubric of “properly qualified” and follows the general convention of referring to midwives with the feminine pronoun, because most midwives are women. See Evenson, \textit{supra} note 3, at 313 n.2.

\textsuperscript{11} The books, hearing transcripts, and articles cited herein represent only a fraction of the growing volume of literature which is responsive to the demands of parents who have been or refuse to be victimized by the zealous application of scientific methodology to a process which, in the majority of cases, is more hindered than helped by such application. See infra notes 25-39 and accompanying text. Senator Edward Kennedy, a concerned lawmaker and father has said:

Modern obstetrics has significantly reduced the risk of childbirth to both mother and child . . . yet problems remain . . . the American lifestyle, combined with the modern practice of obstetrics, has created serious additional health questions and problems for the mother and baby. . . . [T]he development of obstetrical technology far outstrips our capacity to assess its appropriate value. \textit{Obstetrical Practices Hearing, supra} note 6, at 1-2. See also \textit{Brackbill \& Young, supra} note 1, at 57-58, enumerating the reasons given by parents for rejecting the obstetrical intervention approach, including a desire for autonomy, a hostility toward drugs and common hospital birthing practices, and a need for humane and personalized care at a lower cost. \textit{Id.}

\textsuperscript{12} See Note, \textit{supra} note 3, at 78-80; and \textit{Brackbill \& Young, supra} note 1, at 81, which discuss litigation pending in Tennessee where two certified nurse-midwives with physician back-up have been unable to obtain hospital privileges at any hospital in the area. Midwives generally find it desirable to have physician “back-up”, i.e., a doctor on call in the event of medical emergency, because they are fully cognizant of their limitation to attendance at normal, uncomplicated labor, and respect the role of medical technology in saving lives. Midwives usually do not have admitting privileges to hospitals, thus physician
wives are being rewritten, and some judges are dropping the criminal charges filed against midwives. Congressional subcommittees are hearing testimony from experts who decry the laissez-faire approach of the Food and Drug Administration and many obstetrician-gynecologists regarding questionable practices and misinformed consumers. State legislatures are drafting laws more conducive to the conscientious practice of midwifery, and advisory groups have urged the scientific community, under the auspices of the federal government, to conduct intensive research into the respective claims of home birth and hospital birth advocates.

The underlying theme to much of this branch of the law is individual freedom of choice, and that is the perspective of this comment. It will also attempt to convey the sense of urgency gleaned from persons testifying, lobbying, litigating, and educating to preserve the health and well-being of future generations by advocating a return to a non-pathological attitude toward childbirth. That sense of urgency provides the basis for the ultimate conclusion of this comment: that the most responsible way to protect mothers and their newborns now is to decriminalize the practice of midwifery either in court or in the state legislature.


13. A model plan enacted on the federal level provides for reimbursement of midwives independent of physician referral and supervision. Civilian Health and Medical Program of the Uniformed Services, 10 U.S.C. § 1079 (1982). The Medicaid program also allows for nurse-midwives to be paid directly as independent practitioners. 42 U.S.C. §1396(d)(1982). Most states, however, do not have such provisions. See Brackbill & Young, supra note 1, at 82.

14. See Evenson, supra note 3, at 327-28, discussing cases in Tennessee, Florida, and California, which were decided in favor of midwife-defendants.

15. See, e.g., supra notes 4 & 6, for citations to subcommittee hearing transcripts germane to these issues.


17. See Birth Settings, supra note 6. This comprehensive survey reviews the literature available on the subjects of hospital and home births, and, in summarizing it, recommends that priority be given to further research before any definitive conclusions can be reached about the superiority of one system of birthing over another. The authors examine and criticize studies already performed and attempt to establish guidelines to better control research variables in the interest of promoting informed debate and policy development. See also U.S. General Accounting Office, A Review of Research Literature and Federal Involvement Relating to Selective Obstetric Practices (Sept. 24, 1979) [hereinafter cited as GAO Review].
II. REFLECTIONS ON BIRTHING IN AMERICA IN THE 1970’s AND 1980’s

A. The Hospital

The subject to be addressed in this section is the outcome of a typical hospital birth experience.\textsuperscript{18} The average woman, if she is like many women who are concerned about the health of their children and who know about the adverse effects of these substances, will have carefully avoided caffeine, nicotine, alcohol, and over-the-counter drug preparations during the months of pregnancy.\textsuperscript{19} If she has the economic resources and lives in reasonable proximity to medical professionals, she will have been examined periodically by an obstetrician-gynecologist (ob-gyn) with an extensive practice.\textsuperscript{20} She has been weighed at each office visit, has had her urine tested and her blood pressure checked, and has had the growth of the fetus monitored.\textsuperscript{21} Her ob-gyn is not likely to have discussed her

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\item \textsuperscript{18} The description which follows of a typical hospital birth is an illustrative composite; not all procedures are carried out on all women, and many obstetricians-gynecologists (ob-gyns) are beginning to change their practice by not routinely subjecting women to some of the more demeaning procedures which are of little medical benefit. This composite is built upon the statistics which support it, and the statements from women about their in-hospital births included in books such as: BRACKBILL & YOUNG, supra note 1, at 65, 71-72, 87, 94-95, 101; M. SOUSA, CHILDBIRTH AT HOME 21-51 (1976); ARMS, supra note 1, at xiii, 58, 106 & 260-68. The description does not include some of the more damaging practices reported in the literature.
\item A particularly graphic example of gross misuse of drugs is documented in Prescription Drugs Hearing, supra note 6, at 135-36 (news clipping produced for the record by Doris Haire). Estelle Cohen was pressured into a pitocin-induced labor a few weeks before her due date in 1951, and gave birth to a son with brain damage. The physician convinced Ms. Cohen that the drug was medically indicated, but he was actually conducting experiments with it. \textit{Id.}
\item \textsuperscript{19} See ISAACS ASHFORD, supra note 1, at 10-17, for a compendium of the printed materials on drugs and hazards which should be avoided by pregnant women. Caffeine in excess can cause defects of the hands and feet. \textit{Id.} at 15. Nicotine use by the mother is linked to low birth weight, prematurity, and sudden infant death syndrome. \textit{Id.} at 11. Alcohol-related birth defects rank third in causing mental retardation. \textit{Id.} at 13. Substances such as aspirin, antihistamines, tranquilizers, and vitamins in excess have been found to cause a variety of anomalies and defects. \textit{Id.} at 11.
\item \textsuperscript{20} See B. Moburg, Midwives vs. Physicians: Differences in Prenatal and Postpartum Care 14 (June 26, 1984) (Paper presented at the Nat’l Women’s Studies Ass’n Annual Convention, Rut. U.). Based upon questionnaires returned by obstetricians in Northeastern Ohio, the author reports that ob-gyns attend 200 to 300 births each year along with maintenance of their gynecology practices and that a typical prenatal visit is limited to ten minutes. \textit{Id.}
\item \textsuperscript{21} \textit{Id.} at 12. The author contrasts the way her ob-gyn seemingly hoarded the data collected during prenatal visits with the insistence of midwives that a pregnant woman keep her own records and perform her own tests.
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diet with her.22 The typical woman has probably attended prepared childbirth classes and perhaps has read a few books to understand the physiology of pregnancy and birth.23 She may be planning a "natural" childbirth, believing that delivery will be drug free, and, having discussed this with her ob-gyn, she impatiently awaits the day when labor will begin.

When regular contractions indicate that birth is imminent, the American woman enters the hospital.24 She is sent to a labor room where she exchanges street clothes for a hospital gown, is shaved, endures the discomfort of an enema during contractions, and is told to lie down so oxytocin can be administered orally or by IV to strengthen and speed up the contractions.25 Various hospital per-

22. Id. at 3-5. Seventy percent of lay midwives surveyed in Ohio stated that the mother's nutrition habits were of primary concern during the first prenatal visit because midwifery training emphasizes sound nutrition to ensure a healthy pregnancy and birth. On the other hand, medical professionals cling to the notion that the fetus will take what it needs from the mother and only the mother will really suffer from a poor diet. See also Arms, supra note 1, at 118 (discussing the medical tendency to correct problems such as minimal brain dysfunction by procedures performed at birth, instead of "examining the entire pregnancy, beginning with American dietary habits."); and T. Brewer, METABOLIC TOXEMIA OF LATE PREGNANCY: A DISEASE OF MALNUTRITION (1966 & photo reprint 1984) (reporting that many ob-gyns are more concerned about weight gain per se than about the importance of a good diet).

23. A booklist was provided to the author of this comment, who participated in a Childbirth Education Association program in 1974. Recommended books included S. Kitzinger, EXPERIENCE OF CHILDBIRTH (1972); I. Chabon, AWAKE AND AWARE (1966); G. Flanagan, THE FIRST NINE MONTHS OF LIFE (1962).

24. See Evenson, supra note 3, at 315 ("By 1975, over 98% of all births took place in [the] hospital.").

25. See Brackbill & Young, supra note 1, at 4-5 (describing the medical and psychological drawbacks associated with shaving and enemas); Haire, supra note 5, at 17-18 (noting the consequences of shaving and confining the laboring woman to bed, which include risk of infection and creation of apprehension with respect to the former, and disadvantages to the fetus of the latter); and Caldeyro-Barcia, The Influence of Maternal Position on Time of Spontaneous Rupture of the Membranes, Progress of Labor, and Fetal Head Compression, in BIRTH AND THE FAMILY JOURNAL REPRINT 12, 15-18 (1979) (concluding that vertical positions and change of position during labor tend to produce less pain and a shorter labor than a supine position). But see I.M. Gaskin, Spiritual Midwifery 348 (1980) (written by a midwife, this text recommends administration of an enema to stimulate labor). With regard to the use of oxytocic agents used to stimulate labor see GAO REVIEW, supra note 17, at 1-14. This chapter of the GAO report surveys the research literature and concludes that very few studies have been conducted on the long-term effects on children whose mothers have been induced into labor, that the FDA never approved use of some of these hormones and takes many years to remove obviously dangerous products from the market, that their use is widespread even though not medically indicated, with some estimates of use as high as 42.2% of deliveries, and that improper use of the substances can result in suffocation of the fetus and rupture of the uterus. See also BIOMEDICAL INFORMATION CORP., THE OBSTETRICIAN'S AND GYNECOLOGIST'S COMPENDIUM OF DRUG THERAPY 27:1-9 (1981/1982) (reproducing the information contained in manufacturer's package inserts, the oxytocics described all
sonnel come and go, checking her progress, as she tries to manage each contraction with the assistance of a companion and the breathing exercises she has learned.\textsuperscript{26} If she is fortunate, she will be examined briefly by her ob-gyn during the early stages of labor.\textsuperscript{27} If she is in a teaching facility, strangers will frequently enter the room and she will be subjected to a variety of medical interventions for the sake of instruction purposes.\textsuperscript{28} She is not permitted to eat or drink as the hours wear on, and if she is progressing too rapidly, she may be given sedatives or painkillers to mask the intensity of the contractions which were induced by the hormones.\textsuperscript{29} Her waters may be artificially ruptured long before they would have broken naturally,\textsuperscript{30} and she is almost certainly attached to a fetal heart monitor which completely restricts her movements.\textsuperscript{31}

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state that use is not indicated in children or in nursing mothers); \textit{Prescription Drugs Hearing, supra} note 6, at 38 (testimony of Doris Haire of the Nat'l Women's Health Network) (stating that one researcher found a correlation between the use of oxytocin and subsequent learning disabilities in children).
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\textsuperscript{26} \textit{See} Evenson, \textit{supra} note 3, at 313; ARMS, \textit{supra} note 1, at 172.

\textsuperscript{27} \textit{See} Evenson, \textit{supra} note 3, at 313 ("Physicians . . . normally arrive only when . . . the baby [is] ready to be delivered.").

\textsuperscript{28} \textit{See} BRACKBILL & YOUNG, \textit{supra} note 1, at 2, for a discussion of the higher cesarean section rates and greater incidence of neurologically damaged children, as well as higher infant and maternal mortality rates, which are associated with large teaching hospitals. Excessive vaginal exams which increase the risk of infection are also part of the teaching hospital experience. \textit{Id.} at 13-14.

\textsuperscript{29} \textit{Id.} at 5. Fasting is justified by the possibility that general anesthesia will be required, but it serves to weaken the laboring mother. The subject of obstetrical drugs was examined at length by a House subcommittee in 1981. See \textit{Prescription Drugs Hearing, supra} note 6, \textit{passim}. Sluggish respiration is a known response in the infant if the mother is sedated during labor, see \textit{Obstetrical Practices Hearing, supra} note 6, at 25-26 (testimony of Donald Kennedy, Commissioner, FDA), and this condition generally triggers an abnormal heart rate which places the mother at risk for cesarean section. See \textit{BRACKBILL \\ & YOUNG, supra} note 1, at 17. A frequently used narcotic is Demerol, and the adult dosage, at a minimum, is ten times the recommended dosage for even a large fetus. \textit{See} BRACKBILL \\ & YOUNG, \textit{supra} note 1, at 185. Yet, Dr. Robert Bradley found that drugs were unnecessary in 93.5% of the 13,000 births under his care where exercise and emotional support gave the laboring woman all the aid she needed to relieve the discomfort of uterine contractions. \textit{Id.} at 185.

\textsuperscript{30} Large scale data is not available to assess how often artificial rupture of the amniotic membrane, amniotomy, occurs to induce labor. See \textit{COMPTROLLER GENERAL, EVALUATING BENEFITS AND RISKS OF OBSTETRIC PRACTICES} 9 (Sept. 24, 1979). The risks observed in 3,324 elective inductions of labor at the University of Pennsylvania Hospital included the "displacement of the presenting part . . . prolapsed cord . . . and infection." HAIKE, \textit{supra} note 5, at 18. \textit{See also} BRACKBILL \\ & YOUNG, \textit{supra} note 1, at 8-9, for a discussion of the hazards associated with this practice.

\textsuperscript{31} An informal survey conducted by the Senate Subcommittee on Health and Scientific Research indicated that rates of monitoring ranged from 50% to 100%. \textit{Obstetrical
By the time the expulsion stage is reached, the woman is generally unable to work with or respond to the rhythms of her uterine contractions because she either can not feel them or they are occurring too rapidly or powerfully for her to manage. At the first sign of fetal distress registered by machine, the woman will become a surgical statistic and another cesarean section will have been performed. Or if the fetus remains undisturbed through the "pharmaceutical feast" and other medical intrusions, the mother, immediately prior to delivery, is moved to a hospital cart, wheeled down a hall and transferred to an air-conditioned delivery room. She is placed flat on her back in the lithotomy position and her arms are strapped down. She has received an anesthetic by injection.

Practices Hearing, supra note 6, at 3 (data introduced by Senator Kennedy). According to Dr. Arnold Haverkamp, who heads a high risk obstetrics department and who studied electronic fetal monitoring for four years, women who are monitored are nearly three times as likely to undergo cesarean section as those women auscultated, with absolutely no difference in infant outcome. In his words: "I really believe we are overselling our technology...here is an awful lot of monitoring in normal term pregnancies to gain an unclear benefit." Id. at 50-53 (testimony of Arnold D. Haverkamp, M.D., of the Denver Gen'l Hosp.). Electronic monitoring requires the mother to lie still and this is known to lower her blood pressure which decreases oxygen supply to the fetus, resulting in abnormal heart rate, thereby producing the abnormalities which the instrument is supposed to measure. BRACKEILL & YOUNG, supra note 1, at 10-11. Internal fetal monitoring, wherein electrodes are threaded through the vagina and attached to the fetus's scalp, increases the risk of infection and hemorrhages for the mother in addition to the risks associated with early amniotomy, and scalp abscesses, laceration, hematomas and hemorrhages for the baby. Id. at 9-11. In contrast, auscultation is an external, non-intrusive method of listening to fetal heartbeat. See infra note 50.

32. Dr. Haverkamp noted that, based on his study of electronic fetal heart monitoring, see supra note 31, six in 1,000 women undergo unnecessary cesareans which result in a 350% increase in costs and a three fold higher rate of child abuse and deprivation. He also found that 50% of women undergoing cesarean section develop post-operative complications, and once a woman has experienced this form of delivery, the general wisdom is that subsequent babies will be delivered in the same way. Obstetrical Practices Hearing, supra note 6, at 53 (testimony of Arnold D. Haverkamp, M.D.) See also H.I. Marieskind, An Evaluation of Cesarean Section in the United States, EXECUTIVE SUMMARY 1-7 (June 1979). The author of this report found that the rate of cesarean sections increased by 156% between 1968 and 1977, while at the same time births decreased by 12%, and that threats of malpractice suits was the most frequent reason given by physicians for this increased rate of surgery. The second most frequent reason given was that obstetrical training does not include instruction in normal obstetrics and management of labor, whereas technological monitoring is extensively covered. Id. at 6. Cf. Obstetrical Practices Hearings, supra note 6, at 192 (testimony of Ervin D. Nichols, M.D.) (indicating his approval of increased cesarean section rates).

33. BRACKEILL & YOUNG, supra note 1, at 16.

34. See ARMS, supra note 1, at 36, 130.

35. The lithotomy position, requiring a woman to lie on her back, was first introduced in 1738 in France, not because it would be beneficial to the mother or the fetus, but as a convenience to the accoucheur. An influential accoucheur, Francois Mauriceau, the Queen's
tion into her spine or she is gratefully inhaling ether to achieve unconsciousness. With luck, her ob-gyn has arrived to perform an episiotomy that does not damage the sphincter muscles or nerves. Then the ob-gyn pulls the fetus from the birth canal with forceps because the mother is incapable of pushing or participating in any way. She will be shown the baby who has been weighed, rated, washed and wrapped in a blanket. The woman will proceed to the recovery room following another administration of drugs for delivery of the placenta and suturing, while her baby is taken to the nursery or to an intensive care unit for treatment of its drug-created depressed condition.

obstetrician, was responsible for this proposal, justifying it by noting that obstetrical procedures were easier to perform when a woman was lying in bed. See Caldero-Barcia, supra note 25, at 10. The proposal that the knees be drawn up was an early 1800's development, written about by a Philadelphia obstetrician. Id. Dr. Caldero-Barcia, President of the International Federation of Gynecologists and Obstetricians, has studied the effects of maternal position in labor and concluded that the position of choice is vertical and that a horizontal position is associated with a greater incidence of risk to mother and child. Id. passim.

36. See GAO Review, supra note 17, at 15-30. This chapter on medications used to relieve labor pain concludes that use of obstetric medication in the U.S. is extensive with greater than 80% of women receiving at least one type of anesthetic. Id. at 16. It is known that all medications used for pain cross the placenta, but no long-term, large-scale studies have been conducted to assess the effect of such drugs on the infant. Id. at 15, 20. What research has been done indicates that there are enough risks associated with drug use to mandate conservative application. Id. at 21-28. One study has shown that epidural anesthesia creates the same risk for neurologic damage as if the child had been born to a woman subjected to semi-starvation during pregnancy, and that its use increases the likelihood of forceps delivery by 20 times. Prescription Drugs Hearing, supra note 6, at 37. See also Brackbill & Young, supra note 1, at 19, for speculation about how many women could deliver without painkillers based upon statistics from other countries or from alternative birth settings.

37. See Brackbill & Young, supra note 1, at 14-16; S. Kitzinger & R. Walters, Some Women's Experiences of Episiotomy (1981) (based upon the experiences of nearly 1800 women in England and Wales, this study concludes that the procedure is the most commonly performed obstetric operation in the West, is performed without a woman's consent, no research has been done to study the physical or pathological effects, and that pain, lasting for months or years, is more likely to follow an episiotomy than a tear); ARMS, supra note 1, at 98-101 (discussing the lack of medical necessity for the procedure, the arguments used by doctors to support the practice, and the rising extent of performance in the U.S., estimated at over 70%, with a concomitant increase in incisions which cut through the mother's anal sphincter muscle).

38. See GAO Review, supra note 17, at 31-43. Forceps deliveries are estimated to occur in one-quarter to one-third of all hospital births. Id. at 36. The main reason for their use is that analgesia and anesthesia interfere with the mother's voluntary expulsive efforts. Id. at 34. The most common risks include head injuries to the infant and rupture of the mother's uterus or laceration of the vagina. Brackbill & Young, supra note 1, at 22.

39. See Brackbill & Young, supra note 1, at 32-38. Separation of the mother and infant, a conventional hospital routine, seriously interferes with the process of bonding. Animal studies have shown that rejection of the young will follow separation, and studies in human behavior indicate that separated mothers have more difficulty caring for their babies
This woman, if she has delivered vaginally, has been given an average of seven different kinds of drugs, all of which pass to the fetus in adult doses within seconds, and most of which have not been proven safe because the Food and Drug Administration does not permit clinical tests on human fetuses. She has not been informed by her doctor that she and her baby have been subjected to experimental drugs or procedures, nor is she given the facts to weigh the risks involved and to decide whether the unknown long-term effects will be outweighed by the benefits.

She may have been at low risk when she entered the hospital, as are ninety percent of all mothers in this country, but high risk and their babies cry more, gain less weight, and have a higher rate of infection. Id. at 34. Obstetric interventions increase the likelihood of the infant being placed in intensive care, which results in less contact between mother and baby and more risk of infection, because, among other reasons, hospital personnel fail to wash their hands between patients. Id. at 35.

40. Id. at 19. Cesarean delivery requires an average of 15.2 different drugs. Id. See also Obstetrical Practices Hearing, supra note 6, at 10 (remarks of Senator Kennedy) (questioning the FDA Commissioner about his statement that use of drugs was decreasing and referring to a Florida study which found that five or more drugs are given during delivery).

41. Prescription Drugs Hearing, supra note 6, at 163 (testimony of Dr. Yvonne Brackbill) (stating that only one of 58 prescription drugs had been approved by the FDA for use in pregnancy, labor and delivery). See also D. Haire, How the F.D.A. Determines the Safety of Drugs — Just How Safe is “Safe”? (1982). This report, released to Congress, states that safety for the FDA is a relative term and that approval is given to drugs considered to have acceptable risks. Id. at 1. Furthermore, the Committee on Drugs of the American Academy of Pediatrics has cautioned that no drug has been proven risk-free to the fetus. Id. at 5. The FDA does not permit clinical trials of drugs on pregnant women nor does it require follow-up studies to be done on infants exposed to drugs in utero. Id. The FDA advisory committee studying obstetric drugs is comprised of obstetricians, and experts in pediatrics are not regularly consulted by this committee. Id. at 6. According to Doris Haire, it is unlikely that any obstetrician would expose himself or his colleagues to potential malpractice actions which could result from the withdrawal of approval for use of obstetric drugs. Prescription Drugs Hearing, supra note 6, at 5 (testimony of Doris Haire).

42. Prescription Drugs Hearing, supra note 6, at 144. Despite evidence which showed substantial risk of neurological impairment to fetuses, and general support from the medical community for the FDA to require patient package inserts for drugs used during labor and delivery informing mothers of the risks, Congressman Albert Gore noted that pressure from pharmaceutical companies following President Reagan's assumption of office caused the FDA to reverse a developing policy, so that it is no longer committed to informing the public in these matters. Id. Because the drugs administered to laboring women have not been approved for that use, Dr. Brackbill believes that women are being given experimental drugs and have a right to informed consent. Id. at 163. She reported that studies have shown that mothers receive little or no information about the drugs they are given other than the reason for taking them. Id.

43. See ARMS, supra note 1, at 122, stating that 90% of all births require no outside interference. Low risk and high risk are terms which relate to the mother's physical condition and whether or not she can expect a normal pregnancy and birth. Conditions which place the mother at high risk, and therefore make her a candidate for a hospital birth, include: diabetes, excessive overweight, poor health with malnutrition, anemia, or under-weight, toxemia, history of hemorrhage, an active case of herpes, previous cesarean section,
techniques have been employed as standard procedure, and she believes she and her baby could not have survived without her ob-gyn and modern medical technology. What she does not realize is that she has been the unwitting victim of a profitable industry and has probably suffered legally cognizable injury. 

B. The Birth Center or Home

By way of contrast, a birth with a midwife in attendance proceeds at its own pace in an environment generally free of drugs. The prenatal discussions have been lengthy and emphasis has been placed upon diet, exercise, parental responsibility in outcome, and

a breech presentation, premature labor, or multiple birth. Gaskin, supra note 25, at 325. It should be noted that midwives working with traditionally high risk patients have achieved impressive results. See Evenson, supra note 3, at 318 (Frontier Nursing Service midwives in Kentucky, serving a high-risk clientele, recorded eleven maternal deaths for the first ten thousand deliveries, compared to the contemporary national average of 36.3 in 10,000); Prescription Drugs Hearing, supra note 6, at 39 (testimony of Doris Haire) (reporting the superior infant outcome for infants of high risk mothers at the N. Central Bronx Hospital in New York in a program run by midwives).

44. See Brackbill & Young, supra note 1, at 40-42. The authors report that the economic rewards of intervention run into millions of dollars for manufacturers, hospitals, and physicians. An injection of Demeral which costs the hospital thirty cents is billed to the patient at $6.95. Id. at 41. Surgery involves more personnel, each of whom separately bills the patient, id., and equipment costing $10,000 can not be paid for unless it is used. Id. at 42. Further, physicians can charge double the fee for surgical delivery, and obstetricians have doubled their income in the last decade in spite of a decreasing birthrate. Id. at 29-30. See also Arms, supra note 1, at 93 (noting that one fourth of the AMA's annual budget is derived from advertising in its journals by the drug industry).

45. The American Hospital Association published a book by a prominent health care attorney which gathers case law about informed consent and deals with statutory treatment of the doctrine in the states adopting such legislation. J. Ludlum, Informed Consent (1978). As an overview of this area of the law, the author states that the rights of a patient should include: 1) information about the nature of his or her problem; 2) information about alternative courses of treatment; 3) waiver of right to disclosure; 4) information about the degree of risk; 5) a right to reject treatment. Id. at 8-10. Other issues which involve the patient's right to know include: 1) subjection to investigative or experimental procedures; 2) participation in programs used for teaching purposes; 3) identities of those performing critical procedures; and 4) access to medical records. Id. at 10-11. These rights involve a corresponding duty on the part of the physician, and the law clearly requires the physician to communicate with the patient. Id. at 11-12. Although these rights will be determined in light of the pronouncements of the courts and legislature of a given jurisdiction, they provide the foundation for a woman, who is not advised of the risks of obstetrical procedures and who suffers injury to herself or to her child thereby, to bring an action for assault and battery. Id. at 19-20. Informed consent is defined with respect to malpractice actions in Pennsylvania at 40 Pa. Cons. Stat. § 1301.103 (1984). This definition requires a physician to inform the patient of risks and alternatives to proposed procedures or treatments. See also Brackbill & Young, supra note 1, at 94. The authors also note possible contract, products liability, and negligence actions. Id. at 95-100.
The typical woman choosing to birth outside of the hospital with a skilled attendant has done extensive reading on the subject, perhaps even studying the equivalent of a college semester of obstetrics. She is not shaved, no enema is administered, and she can labor in any position or place comfortable to her. Chosen companions are present to assist her through the physical and emotional exertions of labor, her waters remain intact to cushion the fetus as the cervix dilates, and fetal heartbeat is monitored by auscultation.

When the final stages of labor are reached, the mother will be massaged and coached and carefully guided to prevent damage to the fetus by too forceful a push and damage to the mother from tears or bruising. In an ideal setting, medical back-up will be close at hand in the event the midwife and parents judge that complications require such treatment, and the woman will receive the benefits of procedures specifically designed to save life by professionals who are trained primarily to deal with medical emergen-
cies. If the birth occurs in the home or in a birth center, the baby may be placed naked on its mother's breast where it is warmed and encouraged to breastfeed to aid in the bonding process and to promote uterine contractions for the expulsion of the placenta. The umbilical cord is not cut until pulsation ceases, and the midwife continues to monitor the postnatal process, measuring, weighing and rating the baby, administering silver nitrate, all in an environment free of the infectious agents present in the hospital.

The midwife participates in an unobtrusive manner, performing necessary clean-up and staying alert to possible complications. She is an attendant through the entire labor and she merely suggests what the mother can do to facilitate the birth. She waits for the physical process to unfold as it has for centuries and she possesses the skills to recognize and work with the singular characteristics of each normal birth. She also provides postnatal care and advice, having due regard for the unit of mother and child from the early days of pregnancy through the weeks and months following birth, in contrast to the ob-gyn who focuses most concern on fetal outcome during labor and delivery, yet provides no care for the infant after birth.

III. Statutory Treatment of Midwives in Pennsylvania

The law of Pennsylvania on the practice of midwifery dates from the period between 1909 and 1929. The state legislature has not made any substantive changes to this law since then in spite of the burgeoning body of evidence that indicates what is good for physicians and the medical industry is not necessarily what is good for mothers and their infants. This section will review the development of the statutory law and suggest that it is ripe for challenge.
Regulation of Midwifery

by the women whose lives are affected thereby as mothers or as midwives.

On April 27, 1909, the state legislature passed a law forbidding a person in a first class city from practicing midwifery for hire unless licensed by the Department of Public Health and Charities in such cities.\(^{61}\) Violation of the statute carried a one hundred dollar fine, and midwives who had practiced for ten years prior to its adoption were not required to submit themselves for examination prior to obtaining a license.\(^{62}\) On its face, such a law appears to reflect a desire by the legislature to guarantee that persons performing midwifery services in the larger cities would have at least some recognizable level of skill, so that the health and well-being of the citizenry would be safeguarded. No exception was made with respect to licensed physicians, so one would assume that they too were required to undergo examination if they wished to attend women in childbirth.\(^{63}\)

Two years later, however, the legislature passed a new law regulating midwives, and the influence of organized medicine is evident throughout.\(^{64}\) The sources and purposes of this influence have been documented by Polly Radosh, assistant professor of sociology at the University of Minnesota.\(^{65}\) She has found that the medical literature from that era expresses concern that not enough "clinical material" (i.e., parturient women)\(^{66}\) was available for the training of obstetricians whose poor reputation and high patient mortality

\(^{61}\) 1909 Pa. Laws 249. Section 1 provides as follows:
[I]t shall be unlawful for any person or persons, in any city of the first class, to practice the business or profession of midwifery, for hire or reward, except under license to be obtained from the Department of Public Health and Charities in such cities


\(^{63}\) Id. Section 2 provides that:
[N]o person who shall have pursued the business or profession of midwifery, continuously for a period of ten (10) years before the passage of this act, shall be required to undergo an examination as a prerequisite to the obtaining of such license.

\(^{64}\) Id. Section 3 contains the provisions for penalties, assessing guilt upon conviction as a misdemeanor. Id.

\(^{65}\) Id.

\(^{66}\) Id.

\(^{67}\) See infra notes 69-75 and accompanying text.

\(^{68}\) See P. Radosh, The Collapse of Midwifery: Demise or Destruction? (June, 1984) (paper presented at the National Women's Studies Association Annual Convention, Rutgers University).

\(^{69}\) Id. at 7-8 (quoting C.E. Ziegler, Elimination of the Midwife, 59 J. A.M.A. 1738 (1912)).
rate were notorious at the turn of the century.\textsuperscript{67} Although obstetrics was admittedly the weakest branch of medicine, opponents of midwifery were calling for the removal of this obstacle to the advancement of the profession.\textsuperscript{68}

The Act of 1911 forced midwives practicing for ten years to submit proof of practice, attested to by at least two licensed physicians, to the State Medical Council within ninety days of the date of passage.\textsuperscript{69} Those missing the deadline and all others statewide, with the exception of physicians and medical students, were required to hold a diploma from an approved obstetric school or to pass an examination to obtain a license to practice.\textsuperscript{70} The examiner representing the Medical Council was to be a member of the Council, presumably not an experienced midwife, or a legally qualified practitioner of medicine, and applicants were required to show: "a reasonable degree of knowledge of the anatomy of the pelvis, deformities of the pelvis; antisepsis; diagnosis; physiology, and pathology of pregnancy; physiology, mechanism, and management of labor; dystocia, fetal and maternal physiology, and management of puerperium, physiology, pathology, and management of newborn

\textsuperscript{67} Id. at 3. Genuine concern existed, as well, for the dangers posed to women and infants by midwives with little training. Id. at 8. The most reasonable approach at the time would have been to support good training schools and realistic licensure requirements for midwives, but this was not the path taken, because the supply of pregnant women was not seen as adequate for the training of both midwives and physicians. Id. (quoting C.E. Ziegler, \textit{The Elimination of the Midwife}, 60 J. A.M.A. 33-34 (1913)).

\textsuperscript{68} Id. at 7-8. The AMA labored to organize physicians from the time of its creation in 1846, and succeeded in increasing membership from 8,400 in 1900 to 70,000 by 1910. Id. at 4. The goal of the organization was to provide a single medical standard to benefit patients across the nation, and it adopted as means of achieving that goal: 1) the improvement of instruction and research; 2) the limitation of entry into the field; and 3) the elimination of competition via lobbying power. Id. at 5-6.

\textsuperscript{69} 1911 Pa. Laws 928. Section 2 provides that:

All persons practicing midwifery in this State, and who have practiced it for ten years last preceding the date of passage of this act, and desiring to continue the same, shall within ninety days after the passage of this act, make application to the Medical Council of the State of Pennsylvania by submitting an affidavit fully attested, giving the name, age, residence, the length of time during which and the place or places at which the applicant has been engaged in the practice of midwifery, and the special education, if any, which the applicant has received for such practice. Such application shall be accompanied by the affidavits of five (5) freeholders — at least two of which must be licensed practicing physicians — duly attested, that the applicant is known to them as the person applying for a license to practice midwifery and that such applicant has been engaged in the active practice of midwifery, giving the location or locations of such practice, for the ten years last preceding the date of the passage of this act.

\textit{Id.}

\textsuperscript{70} 1911 Pa. Laws 928. Sections 1, 3 & 14.
Although such requirements were a laudable attempt to provide laboring women with skilled attendants, the exemption of physicians and medical students from examination was designed to create a situation whereby midwives would face barriers to practice for the sake of the economic and educational interests of medical professionals who remained free to practice regardless of ability. It must be noted that as late as 1921, a survey of obstetrical training institutions revealed that sixteen of forty-three merely required four years of high school for entrants, and only eleven required two or more years of college for admission. Furthermore, less than half of the faculty members of all obstetric schools had trained at lying-in hospitals, and of this group, only five had trained for more than one year, five had trained for six months, and eleven had less than five month's on-the-job experience. The question which immediately comes to mind is whether medical students working under such direction would have had the knowledge to pass the examination required of midwives.

Certain acts were absolutely forbidden to anyone but a physician by the 1911 statute, and midwives were forbidden from engaging in any other branch of medical practice. Penalties included fines and/or imprisonment, and further exceptions were made for emergency or gratuitous obstetrical services.
Evidently, such legislation was not enough of a hindrance to practitioners of midwifery, because the legislature repealed the Act of 1911 on June 5, 1913, with passage of a new midwifery act.\textsuperscript{76} The preamble refers to the lives of women and children sacrificed due to the ignorance and incompetency of midwives,\textsuperscript{77} thus indicating that the propaganda campaign by medical professionals had taken hold where it mattered most for the sake of eliminating competition.\textsuperscript{78} In fact, the very midwives excoriated in the literature, especially those practicing in Europe, were better trained in physiology and the complications of pregnancy as well as in the management of labor than were American physicians.\textsuperscript{79} It should have been no surprise then that large immigrant populations preferred midwives to physicians.\textsuperscript{80}

The Act of 1913, therefore, made no provision for midwives with ten year's experience and no exception for gratuitous or emergency obstetric services.\textsuperscript{81} All powers and standards of certification were vested in the State Bureau of Medical Education and Licensure, and, as before, licensed physicians, medical students, and duly certified midwives were the only groups permitted to attend women in childbirth.\textsuperscript{82} The statutory language used the feminine pronoun gratuitously\textquoteright\).

76. 1913 Pa. Laws 441. The preamble stated that the Act of 1911 had proved defective. \textit{Id.}

77. \textit{Id.} The preamble used the following words:

\textit{Whereas, The lives of many women and children are needlessly sacrificed in childbirth, and the vision of many newborn children is seriously injured or totally destroyed through the ignorance and incompetency of persons engaged in the practice of midwifery . . . .}

\textit{Id.} Many midwives did not apply silver nitrate to the eyes of newborns, a procedure designed to counter the effects of possible infection by gonorrhea, because they feared prosecution for the illegal use of drugs. \textit{See} Radosh, \textit{supra} note 65, at 21 (speculating that most midwifery legislation was a genuine attempt to prevent blindness in newborns rather than an effort to simply eliminate midwives). The Pennsylvania law recognized the problem, but provided no authorization for midwives to correct it. 1913 Pa. Laws 441.

78. \textit{See} Evenson, \textit{supra} note 3, at 315-16 (finding authoritative evidence that midwives had as much or more success in the field than medical professionals at that time, but that organized medicine campaigned strenuously to outlaw midwifery); and Radosh, \textit{supra} note 65, at 8-10 (discussing the comparative records of midwives and physicians and the need for the medical profession to "educate" the public to the dangers of midwives and pregnancy to gain professional domination).


80. \textit{Id.} at 9-10.

81. 1913 Pa. Laws 441. Section 1 stated:

\textit{It shall be unlawful for any person, except a duly licensed physician, to practice midwifery in this State . . . .}

\textit{Id.}

82. 1913 Pa. Laws 441. \textit{See} Sections 1, 2 & 7. \textit{SMull\textquoteright s Legislative Handbook} 88-89
with respect to midwives and imposed fines and/or imprisonment for practicing midwifery without a certificate.\textsuperscript{83} Medical students were referred to by the masculine pronoun, hence lending credence to Radosh's theory that the rise of the medical profession in this country at the expense of a traditionally female occupation was deeply rooted in the sexism used to justify the actions of medical professionals at that time.\textsuperscript{84}

The current law regulating midwives was enacted in 1929.\textsuperscript{85} and all prior statutes on the subject were expressly repealed.\textsuperscript{86} A fine or imprisonment in default of payment is imposed for the practice of midwifery without a certificate,\textsuperscript{87} and the State Board of Medical Education and Licensure is empowered to issue regulations respecting the qualifications and requirements leading to certification.\textsuperscript{88} Physicians are appointed by the Secretary of Health to in-

\textsuperscript{83} 1913 Pa. Laws 441. Section 6 provided:

Any person practicing midwifery as a profession, or advertising herself as a midwife, without first obtaining the certificate aforesaid, shall be deemed guilty of a misdemeanor, and upon first conviction shall be punished by a fine of not less than ten dollars nor more than fifty dollars, or by imprisonment in the county jail not less than ten days nor more than sixty days, or both fine and imprisonment at the discretion of the court.

\textsuperscript{84} 1913 Pa. Laws 441. Section 7 exempted medical students with this language:


\textsuperscript{87} 1929 Pa. Laws 160. Section 5 provided for:

\textsuperscript{88} 1929 Pa. Laws 160. Section 2. 63 PA. CONS. STAT. § 172 (1984). The current regula-
spect, supervise, control, and instruct midwives,\textsuperscript{89} and only licensed physicians, osteopaths, and medical students are excluded from the definition of persons to be regulated by the statute.\textsuperscript{90} Thus, the monopoly of the medical profession over birth in Pennsylvania has been legitimized by the legislature for over fifty years.

As American medicine became professionalized, lay practitioners were restricted by laws responsive to the American Medical Association, and eventually were no longer in demand as the country became convinced by the medical literature that midwives were backward, dirty, ignorant, and incapable of handling an event that was viewed as rarely normal and always fraught with danger.\textsuperscript{91} Today, however, with more consumers questioning such medical wisdom, and with statistics supporting a genuine concern about the hazards associated with technological obstetric interventions,\textsuperscript{92} the law stands in the way of ensuring that enough midwives will be available to meet the needs of those choosing to reject the hospital setting and gadgetry.\textsuperscript{93}

Although no laws exist forcing a woman to give birth in a hospital, the criminalization of a practice by which eighty percent of the world gives birth,\textsuperscript{94} and by which most Americans gave birth through the early part of this century,\textsuperscript{95} has had the effect of limiting access to a viable health care alternative.\textsuperscript{96} In addition, women

\begin{footnotes}
\item[91] See Evenson, supra note 3, at 316; Radosh, supra note 65, at 11-14.
\item[92] See supra notes 22-40 and accompanying text.
\item[93] See Evenson, supra note 3, at 327-29 (noting the increase in elective home deliveries regardless of the position of the medical profession and the illegality of or restrictions on the practice of midwifery in many states). See also supra note 47.
\item[94] See Isaacs Aschford, supra note 1, at 112.
\item[95] See Evenson, supra note 3, at 315 (stating that more than 50% of all births in the U.S. were attended by midwives in 1900); Birth Settings, supra note 6, at 2 ("Less than 5% of the babies born in 1900 were delivered in a hospital.")
\item[96] President John F. Kennedy, more than twenty years ago, set forth a consumer bill
\end{footnotes}
who are suited by temperament for such services and who feel compelled to provide other women with support during labor and delivery may not do so unless they first embark upon a pathologically oriented, expensive course of study which teaches methods that have made low risk childbirth a perilous experience.

Educating the public to view standard obstetric practices with skepticism is a tactic chosen by some midwifery groups,97 who are learning from the process by which physicians sought legitimization more than fifty years ago. Other groups are lobbying for changes in certification laws,98 and individuals nationwide conduct personal campaigns reaching into national forums.99 Such methods, however, will only bear fruit at some unknown time in the future, as countless women continue to undergo unnecessary administration of drugs and techniques which lead to more unnecessary drugs, episiotomies, forceps deliveries, and cesarean sections. If laws restricting access to birth control and abortion can be struck down by judicial fiat,100 then mothers and midwives should not hesitate to challenge a fifty-five year old law in the courtroom, as well as in the corridors of power in the state capitol.

IV. THE CASE FOR A COURT CHALLENGE

The laws regulating midwives in Pennsylvania have never been

of rights, because he was concerned about the lack of lobbying power on the part of the individual consumer. He believed that the consumer had a right to be protected against hazardous products, a right to be given the facts to make an informed choice, and a right of access to a variety of services at competitive prices. See Rothman & Rothman, The Professional Nurse and the Law 83 (1977). Because properly qualified midwives offer a safe and satisfying birth experience, there is little excuse for lawmakers to continue to extend special privileges to the medical profession, which preempted the field before it could prove it was qualified to do so, see supra notes 66-73 and accompanying text, and which poses a threat to basic consumer rights today. See supra notes 25-45 and accompanying text.

97. The Women's Rights Project of New Jersey has reported that the New Jersey chapter of the American College of Nurse-Midwives and the lay midwifery movement in the state believe that educating the general public is the best way to advance midwifery as a health care option at this time. See S. Cohen, Women's Rights Project 1984-85 (unpublished statement of Project Director).

98. See Sallomi, supra note 10 (detailing the lobbying efforts of midwives on a state-by-state basis).

99. See Prescription Drugs Hearing, supra note 6, at 167-68, 244 (remarks of Rep. Albert Gore) (recognizing the activism of Doris Haire and Dr. Yvonne Brackbill, who had testified at the hearing, in contrast to the attitudes of professionals who admit they are too busy to change the status quo with respect to the lack of knowledge about drugs used during labor and delivery).

100. Roe v. Wade, 410 U.S. 113 (1973) (overturning the Texas criminal abortion laws); Griswold v. Connecticut, 381 U.S. 479 (1965) (invalidating the Connecticut statute which made the use of contraceptives a criminal offense).
analyzed from a constitutional rights perspective in the courtrooms of the Commonwealth. In fact, since enactment in 1929, not one judicial opinion has been recorded as interpreting, defining, or supporting this particular exercise of legislative power.\textsuperscript{101} Although at least one commentator has opined that the birth attendant controversy may best be resolved in the political arena,\textsuperscript{102} this section will examine recent case law concerning the doctrine of the right of privacy in this jurisdiction and will propose that precedent favors the litigant who challenges midwifery regulation as an unjustifiable burden on individual rights.

One court is known to have considered the constitutional right of privacy in relation to midwifery regulation. The defendants in \textit{Bowland v. Municipal Court}\textsuperscript{103} argued that a woman's right of privacy was violated by laws forbidding the practice of midwifery because those laws restrict choice of birth attendant. The California Supreme Court rejected such a theory, holding that the U.S. Supreme Court pronouncements on the subject in \textit{Roe v. Wade}\textsuperscript{104} did not extend this elusive doctrine quite so far.\textsuperscript{105} A commentator has reexamined this decision in light of changes made in the state constitution and several other subsequent privacy decisions and concludes that the high court of California could correctly overturn \textit{Bowland} now on this issue.\textsuperscript{106}

The Pennsylvania Supreme Court has also considered privacy rights based upon the authority of U.S. Supreme Court decisions, but the tenor of these opinions indicates that privacy and family rights are held in extremely high regard in this jurisdiction. A case upholding the right of a patient to keep psychiatric treatment records private, \textit{In re "B"},\textsuperscript{107} sets the foundation for the doctrine

\textsuperscript{101} See \textit{PA. STAT. ANN.} tit. 63, §§ 171-76 (Purdon 1968 and Supp. 1984-85). No case citations follow these statutory sections and a LEXIS search failed to locate any cases on this subject. Radosh believes that the lack of resistance to the medical campaign which sought to eliminate midwifery was due more to the degree of fragmentation among midwives than to any truth to allegations of incompetence. \textit{See supra} note 65, at 22. This lack of organization must be responsible for the absence of court challenges to the law in Pennsylvania.

\textsuperscript{102} \textit{See} \textit{Evenson, supra} note 3, at 330.

\textsuperscript{103} 18 Cal. 3d 479, 556 P.2d 1081, 134 Cal. Rptr. 630 (1976).

\textsuperscript{104} 410 U.S. 113 (1973).

\textsuperscript{105} The \textit{Bowland} court held that \textit{Roe v. Wade}, 410 U.S. at 164-65, established the principle that the state's interest in the life of the unborn child supersedes a woman's right of privacy at the point of viability. \textit{See Bowland}, 18 Cal. 3d at 495, 556 P.2d at 1089, 134 Cal. Rptr. at 638.

\textsuperscript{106} \textit{See} \textit{Caldwell, supra} note 3, at 19-20.

\textsuperscript{107} 482 Pa. 471, 394 A.2d 419 (1978).
with these words: "The right of privacy derived from these constitutional underpinnings protects the privacy of intimate relationships like those existing in the family, marriage, motherhood, procreation, and child rearing." Similar language appears in *Fabio v. Civil Service Commission*, with regard to a police officer's dismissal on the basis of private sexual behavior. The *Fabio* court ruled that government can regulate activity where its interest is sufficiently compelling, even if such activity is constitutionally protected. This analytical framework is applied as well in cases bearing a closer resemblance to the choice of birth setting and birth attendant controversy. Involuntary termination of parental rights cases illuminate the tension between the state, as *parens patriae*, and parents, as individuals with a constitutional right of privacy in family matters.

*In re William L.* is one such case wherein the court responded to a due process challenge which alleged a constitutional violation of a family's interest in mutual association, by discussing the right of privacy as defined by the U.S. Supreme Court. The *William L.* court did not find the right to be absolute, holding that it is subject to the state's authority to intervene to protect minor children. The court found that the balance to be struck is weighted upon "the child's essential health and safety needs," and the court closely examined the interests of state and parent with respect to those needs. This theme resounds in a more recent appellate decision, *In re F.L.D.*, in which the court, facing a similar challenge to the involuntary termination of parental rights statute, held: "As parens patriae, the state may limit the power of the parent if it appears that parental decisions will jeopardize the health or safety of the child, or have a potential for significant social burdens."
When this authority is applied to midwifery regulation, one can see that a parental decision to reject the medical establishment during a normal, low risk birth is made within the context of decisions and relationships sanctified by natural law and preserved by the constitution. The mother who conscientiously chooses to give birth without the standard obstetrical intrusions has the best interests of her infant in mind. The burden is upon the state to show that this decision jeopardizes the infant’s health to thereby justify regulations which burden the mother’s ability to make that decision. It is clear that the state can not prove that strict limitations on the practice of midwifery are protective of the health and safety of infants. By so limiting the ranks of nonmedical birth attendants, at the request and instigation of health professionals, the state has participated in a system which forces women into the realm of organized medicine where they lose control of a process increasingly endangered by personnel who treat birth as a disease with a profusion of drugs, devices, and procedures of questionable benefit.

The court faced with a challenge to the midwife statute either by parents or lay midwives should not hesitate to strike it down.

\[117. \text{63 PA. CONS. STAT. §§ 171-76 (1984).} \]
\[118. \text{See supra note 43.} \]
\[119. \text{See Rinker Appeal, 180 Pa. Super. 143, 147-48, 117 A.2d 780, 783 (1955) (describing the family as an institution which predated government with rights between mother and child created by natural law).} \]
\[120. \text{See Caldwell, supra note 3, at 23 (stating that the interests of state and mother, although at odds with respect to third trimester abortion, are perfectly compatible in childbirth).} \]
\[121. \text{See Pennsylvania Supreme Court Review, 1978, 52 Temp. L. Q. 589, 815-25 (1979) (discussing parental rights in conflict with state interests and U.S. Supreme Court doctrine establishing the burden states must meet when encroaching upon constitutional rights); Note, supra note 3, at 703 (stating that government should bear the burden of proving that a midwife-assisted birth is not as safe as traditional medical practice, because midwife regulations should be subject to the same review as abortion regulations).} \]
\[122. \text{See supra notes 25-44 and accompanying text. See also Caldwell, supra note 3, at 24-25 (reporting statistics which show that mortality and infection rates are lower for home births with midwives in attendance than comparable hospital results).} \]
\[123. \text{See supra notes 65-68 and accompanying text.} \]
\[124. \text{See Caldwell, supra note 3, at 30-31 (stating that stringent statutory regulation of midwives has seriously restricted access to them by pregnant women); Interview with Ellen Graefke, supra note 10 (indicating the difficulty her students have locating birth attendants who will respond to their demands which would restrict use of drugs and other procedures during birth). See also supra notes 25-44 and accompanying text (describing the risks associated with hospital births).} \]
\[125. \text{63 PA. CONS. STAT. §§ 171-76 (1984).} \]
\[126. \text{See Note, supra note 3, at 683 (setting forth the principles which give midwives standing to assert the constitutional rights of their clients). See also Comment, Restrictions} \]
There are states, among them Texas,\textsuperscript{127} where midwives attending normal births are completely unregulated with no adverse impact upon the quality of care women and their infants receive during labor and delivery.\textsuperscript{128} In stark contrast, the highest black infant death rate in the nation has been recorded most recently in Pittsburgh, Pennsylvania.\textsuperscript{129} If that city's pregnant women could be served by low cost prenatal education and care through a program administered by large numbers of midwives working beyond the confines of hospitals, the infant death rate would decrease.\textsuperscript{130} The law, however, stands in the way of achieving that goal. Many black women will continue to receive inadequate prenatal care due to its inflated expense and lack of community outreach.\textsuperscript{131} The prospect for the future is dimmer still, because the state agency which certifies midwives is slated to terminate on December 31, 1985.\textsuperscript{132} The number of certified practitioners of midwifery statewide would be frozen in the event the legislature fails to reestablish the agency.\textsuperscript{133} If the agency were reestablished, however, the law would continue to require unnecessary years of education for midwives, with the

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\textit{on Unorthodox Health Treatment in California: A Legal and Economic Analysis, 24 U.C.L.A. L. Rev. 647, 675-80 (1977) (indicating the lack of success by those challenging medical licensing requirements because such regulations are considered to involve economic interests which are subject to a rational basis test, and outlining the better approach for relaxing restrictions on unorthodox treatments which is based upon the right of a patient to choose his or her own treatment).}
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\textsuperscript{127} See Toth, \textit{New Health Professionals: The Physician Assistant and Advanced Nurse Practitioner in Texas}, 22 S. Tex. L. J. 132, 140-42 (1981) (stating that Texas generally permits midwife practice, because Texas law does not deem that attendance at uncomplicated births is within the practice of medicine).

\textsuperscript{128} The Association of Texas Midwives conducts its own midwifery certification program to ensure that midwives practicing with its endorsement meet criteria conducive to reliable assistance at birth. See Sallomi, \textit{supra} note 10, at 24. Thus, a non-medical profession polices its own members and does no worse than medical professionals. The infant mortality rate for the state of Texas in 1977 was 14.7 deaths per 1,000 births. This compares favorably to the national rate of 14.1 deaths per 1,000 births for that year. \textit{The Statesman's Yearbook} 1378, 1538 (J. Paxton ed. 1982-83).

\textsuperscript{129} On August 6, 1984, the KDKA Evening News reported that the black infant death rate in Pittsburgh is 30 in 1,000 births, prompting an investigation and promise of action by Senator Arlen Specter.

\textsuperscript{130} See Merrow, \textit{supra} note 5. The Merrow documentary also reported that nurse practitioners providing prenatal care for the poor in rural Louisiana have cut the infant death rate in half. See also note 42 for a discussion of midwife programs which have resulted in superior outcomes among impoverished clients.

\textsuperscript{131} See \textit{supra} note 9.


practical effect of barring many who would otherwise embrace the occupation.\textsuperscript{134} The statistical evidence supports a challenge to the midwifery law in court,\textsuperscript{135} and constitutional principles could provide the best approach to the judicial branch in this jurisdiction. In the absence of action by the legislature for fifty-five years, the courts could act within the limits of judicial power to rule that current midwifery regulations\textsuperscript{136} are not the least burdensome encroachment upon fundamental freedoms.\textsuperscript{137}

V. Conclusion

Medical advances in this century have made the process of birth less of a mystery, thereby improving outcomes for mothers and infants otherwise at risk due to infrequent, but life-threatening, complications. By elevating obstetrical technology to a position of primacy, however, the medical profession has forgotten that a natural physical event initiates the first major passage of each new life. This event perpetuates the species according to rhythms established by complex physiological interactions which are carefully balanced. Traditionally, women have attended each other in labor, waiting for the drama of birth to occur as it has for hundreds of years, with no minor success, and they have wisely not presumed to rewrite the script. Together, medical professionals and midwives could provide parturient women with a superior birthing experience, and this has been shown by the results achieved in the Netherlands, where fifty percent of the births occur at home with midwife assistance.\textsuperscript{138}

The American College of Obstetricians and Gynecologists is ada-

\textsuperscript{134} See Evenson, supra note 3, at 326 (stating that, according to some nurse-midwives, their nursing training has scant application to the practice of midwifery, particularly in alternative birth settings).

\textsuperscript{135} See Note, supra note 3, at 703. If the government must show that midwife-assisted births are unsafe to support its regulation of midwifery, it will fail because the evidence, although not conclusive, suggests that alternative birth settings and alternative birth attendants do no worse than obstetricians in hospitals. See GAO Review, supra note 17.

\textsuperscript{136} 63 PA. CONS. STAT. §§ 171-76 (1984). See Caldwell, supra note 3, at 31 (commenting that the dilemmas associated with strict regulation of midwives should be solved by courts in the absence of legislative solutions).

\textsuperscript{137} See Pennsylvania Supreme Court Review, 1978, supra note 121, at 826 n.59 (finding that the U.S. Supreme Court has said that the state must choose the least burdensome means when pursuit of legitimate objectives encroaches upon constitutionally protected activity, citing Eisenstadt v. Baird, 405 U.S. 438 (1972)).

\textsuperscript{138} See Gilgoff, supra note 1, at 41-42 (stating that figures from the U.N. Demographic Yearbook place the Netherlands in the top three nations with lowest infant mortality rates).
Regulation of Midwifery

...antly opposed to the independent practice of midwifery, and it is likely that the laws the profession pushed through state legislatures within the last six decades will remain on the books for many more years. Enlightenment comes slowly, and most women will not lobby for change because they believe that the doctor knows best and that drugs, surgery, and machines comprise the necessary birth experience in modern America. Hospital personnel dispense drugs, because they can not provide emotional support; doctors do not spare the scissors, because they have never experienced the after effects of an episiotomy; drug manufacturers produce experimental wares and watch their profits rise, because they are not responsible for hyperactive or emotionally imbalanced children; and the poor lose their young, because prenatal care lies beyond their ability to pay.

One litigant presenting her case before one judge could stem the tide of high-tech birth. The judge will recognize that privacy includes the right of a mother to choose an "alternative" birth practice. The judge will put the state's interest in birth on the stand and will rule that criminalization and strict regulation of midwifery by the medical profession unconstitutionally burden the exercise of a fundamental right, because the state can not justify benefiting a lucrative industry at the expense of its minor citizens. Midwifery will have a place in the future, but the courts may have to jolt the consciences of medical profiteers to foster a legal environment conducive to the existence of a time-tested and honorable profession.

_Dale Elizabeth Walker_

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139. _See_ Evenson, _supra_ note 3, at 319 n.60 (indicating that ACOG regards home birth as "child abuse" and that the medical profession is less than enthusiastic about the practice of midwifery).