

PUSHING FOR CHANGE: The State of Arizona Should Allow Women Greater Access to Midwifery Care

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I. INTRODUCTION

The evidence in support of homebirths continues to pile up, and yet many states, including Arizona, continue to be influenced by the powerful lobby rather than by the facts and interests of the primary stakeholders, mothers, and babies. Maternal health in the United States is in a state of crisis with 437 woman dying annually (13 deaths per 100,000 births) from childbirth or complications from childbirth.¹ The Center for Disease Control (CDC) estimates that half of these deaths are preventable.² Recently, there has been a grassroots movement among woman to find direct entry midwives and birth at home.³ But there has been push-back from the medical community and state legislatures.⁴ The medical community claims that hospitals are the safest

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1. AMNESTY INT'L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 1 (2010) (illustrating the high number of women that die in childbirth as recorded in 2006 by the United States Department of Health and Human Services).

2. *See id.* at 3.

3. *See generally* Debra Boucher et al., *Staying Home to Give Birth: Why Women in the United States Choose Homebirth*, 54 J. MIDWIFERY & WOMEN'S HEALTH 119, 121–25 (2009) (explaining survey done of women who chose to give birth at home in the United States and asking women's personal reasons for choosing homebirths); Samantha M. Shapiro, *Mommy Wars: The Prequel, Ina May Gaskin and the Battle for at-Home Births*, N.Y. TIMES MAG. (May 23, 2012), http://www.nytimes.com/2012/05/27/magazine/ina-may-gaskin-and-the-battle-for-at-home-births.html?_r=1 (giving an account of author's personal experience of women choosing homebirths and the author's interview with Ina May Gaskin about her experience assisting in homebirths).

4. COMM. ON OBSTETRIC PRACTICE, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 697, PLANNED HOME BIRTH 1 (2017), <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co697.pdf?dmc=1&ts=20170522T1450537246> (last visited May 22, 2017) (declaring that

place to give birth, yet these numbers come from hospital births since most births in the United States occur in hospitals under the care of doctors.⁵ The American College of Obstetrics and Gynecology (ACOG) has repeatedly spoken out against the safety of homebirths and only recently has acknowledged the safety of birthing at a freestanding birth center assisted by a midwife.⁶ Other countries have more integrated systems that allow low-risk women to see and give birth at home with a midwife.⁷ These countries also have better maternal and infant mortality rates.⁸

Some states base their restrictive regulation of midwives on wanting to protect the child, discrediting a woman's desire to do what is best for her and her unborn child. A woman's decision to have a homebirth might be motivated by a previous birth experience in the hospital, stories from friends, an awareness of the high amount of unnecessary interventions that can lead to cesarean sections, or just an intuition that she would feel more relaxed and secure giving birth in the safety of her own home. Despite the claims of opponents of homebirths, women who are seeking to have a homebirth while assisted by a midwife have done their research.⁹ And the research supports their decision. Recent studies on homebirths show that birthing at home is just as safe as birthing in a hospital.¹⁰ A recent study in the Netherlands found

the American College of Obstetricians and Gynecologists (ACOG) does not support any homebirth assisted by a lay midwife, which is a midwife not certified by the American Midwifery Certification Board); *American Congress of Obstetricians and Gynecologists 2017 Legislative Priorities*, ACOG, <http://www.acog.org/Advocacy/ACOG-Legislative-Priorities> (last visited Mar. 11, 2017) (listing the goals of the American Congress of Obstetricians and Gynecologists (ACOG) for lobbying Congress during the 2017 legislative year including eliminating funding for any non-medically trained midwives that assist at homebirths).

5. AMNESTY INT'L, *supra* note 1, at 70, 79–81, 87–90.

6. See generally AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, OBSTETRIC CARE CONSENSUS: LEVELS OF MATERNAL CARE NO. 2, at 1–2 (2016), <http://www.acog.org/-/media/Obstetric-Care-Consensus-Series/oc002.pdf?dmc=1&ts=20170521T2118357262> (proposing a uniform definition for maternity care with varying levels of acuity from birth centers for low-risk women to Level IV centers that are capable to take care of women in critical condition and equipped with an Intensive Care Unit).

7. See generally AMNESTY INT'L, *supra* note 1, at 1, 81.

8. *Id.* at 1; WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2010 (2010).

9. Carol Sakala & Maureen P. Corry, *Listening to Mothers II Reveals Maternity Care Quality Chasm*, 52 J. MIDWIFERY & WOMEN'S HEALTH 183, 183–85 (2007).

10. See, e.g., Melissa Cheyney et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 25–26 (2014); A de Jonge et al., *Perinatal Mortality and Morbidity in a Nationwide Cohort of 529,688 Low-Risk Planned Home and Hospital Births*, 116 BJOG: INT'L J. OBSTETRICS & GYNECOLOGY 1177, 1177 (2009); Patricia Janssen et al., *Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician*, 181 CANADIAN MED. ASS'N J. 377, 379 (2009).

that birthing at home does not increase the risk of dying during, or from complications of, childbirth.¹¹ Similarly, a study of planned homebirths in the United States assisted by a midwife found that even without a supportive infrastructure homebirths are just as safe as hospital births (0.85 deaths per 1,000 births).¹² And most recently, Great Britain published recommendations that low-risk women see a midwife and give birth at home.¹³

The evidence proves that homebirths are just as safe as hospital births and provide significant cost saving for individuals, insurance companies, and taxpayers. Further, a woman's right to a homebirth is protected by the Due Process Clause of the Fourteenth Amendment which allows an individual to refuse medical treatment for any reason, even when the life of a third party is at risk.¹⁴ Despite these facts, the Arizona state legislature is standing in the way of women wanting to birth at home while violating their Fourteenth Amendment right to refuse medical treatment when they want to use the services of a licensed midwife.

Arizona, and all states, should have less laws restricting women seeking and using trained midwives as their birth care providers and planning homebirths and should encourage healthy low-risk women in choosing this option for themselves and their babies. This paper argues, first, that the current maternal health care system in the United States is in need of serious reform, and wider use of midwives is one aspect of reform with proven results. Second, this paper will illustrate that midwives are trained professionals who have the knowledge and skill to offer women the care currently lacking in the hospitals. Third, this paper will argue that pregnant women are being denied their constitutional rights under the Due Process Clause of the Fourteenth Amendment when doctors and courts dictate what medical procedures pregnant women are allowed to refuse or seek out. Fourth, this paper will show evidentiary support that midwifery care is safe for both women and children and widely used throughout the world. Lastly,

11. de Jonge et al., *supra* note 10, at 1177.

12. Cheyney et al., *supra* note 10, at 25.

13. *Intrapartum Care for Healthy Women and Babies, Clinical Guideline*, NAT'L INST. FOR HEALTH & CARE EXCELLENCE, <https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-pdf-35109866447557> (last visited May 21, 2017) [hereinafter NICE GUIDELINES] (giving updated guidelines based on the most recent data that women may safely birth at home and should be made aware of this option and highlighting the need to respect the mother and her family as the primary decision-makers in the birthing process which should be assisted by medical personnel—not dictated by them).

14. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278–79 (1990); *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91–92 (Ct. C.P. 1978) (denying request to compel competent adult to submit to bone marrow surgery in order to help another in need, citing common law tort concept that there is no duty to rescue and that requiring an adult to succumb to bodily intrusion goes against the ideals of the United States).

this paper will analyze the current Arizona administrative laws regulating homebirth midwifery care to show the many areas that can be improved to both respect the mother as decision-maker in the birthing process and provide midwives with all the tools needed to ensure safe outcomes for mother and child.

II. OVERALL MATERNAL CARE IN THE UNITED STATES IS IN SERIOUS NEED OF REFORM

Women in our country are not getting the care they deserve and there are many factors causing this disturbing fact. The United States currently ranks fiftieth in the world for maternal mortality rates and forty-ninth in the world for infant mortality.¹⁵ The reasons include high costs, lack of access, high intervention rates, and high rates of cesarean sections.¹⁶ Other countries have much lower rates of maternal and infant mortality rates while relying less on medically assisted births.¹⁷ In these countries, midwives attend most births.¹⁸ Shifting the way pregnancy is handled in the United States can lower costs and mortality rates. Currently in the United States there is a small proportion of obstetricians per birth (9.6 per 1,000 births) and the lowest proportion of midwives to birth (0.4 per 1,000 births) of any of the industrialized countries.¹⁹ An increased use of midwives to provide care for women with low-risk pregnancies could provide greater access to prenatal care for all women.²⁰ We should embrace collaboration between medical doctors and trained midwives rather than pitting the two fields against each other. Midwives can provide the individual and personalized care that many women seek while doctors remain available to treat complications and women facing high-risk pregnancies.

Even with poor results, the United States still spends the most on maternity care in the world.²¹ Maternity care in the United States is the leading cause of

15. AMNESTY INT'L, *supra* note 1, at 1.

16. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 2 (2008), <http://www.nationalpartnership.org/research-library/maternal-health/evidence-based-maternity-care.pdf>.

17. AMNESTY INT'L, *supra* note 1, at 1; de Jonge et al., *supra* note 10, at 1182.

18. AMNESTY INT'L, *supra* note 1, at 63; *Mother Friendly Birth Initiative*, IMPROVING BIRTH COALITION <http://www.motherfriendly.org/MFCI> (last visited May 22, 2017) (listing the need to improve maternity services in the United States including that the countries with the best perinatal outcomes have midwives assisting most of the births).

19. AMNESTY INT'L, *supra* note 1, at 62.

20. *Id.*; SAKALA & CORRY, *supra* note 16, at 5.

21. AMNESTY INT'L, *supra* note 1; SAKALA & CORRY, *supra* note 16, at 3.

hospitalization for women of childbearing age and infants.²² And maternity care is the largest health care expenditure in this country.²³ These costs are shared among private insurance companies (51%) and government assistance (42%).²⁴ Everyone in the country has an interest in lowering the costs of maternal care. For an uncomplicated vaginal delivery in a hospital, the cost averages \$7,000 nationwide, while the cost of the same delivery at a free-standing birth center averages only \$1,600 nationwide.²⁵ In Arizona, the numbers average \$2,450 for a birth center and \$10,197 for a hospital birth.²⁶ The discrepancy in costs only increases when looking at cesarean sections, which average \$17,000 when no complications arise.²⁷ While cesarean sections are a great advancement in medicine when necessary, the rate of cesareans in the United States exceeds what is considered healthy and necessary by the World Health Organization (WHO).²⁸ WHO suggests both very high rates and very low rates of cesareans put women at risk.²⁹ The last number given by WHO as providing the best results for mother and baby was 15%.³⁰ In the United States, the current rate is around 30%.³¹ Even more startling is that the occurrence of cesareans has increased while the problems they are said to prevent, such as cerebral palsy and mental retardation, have stayed the same (or increased).³²

Studies suggest the rate of cesareans is high in the United States due to women choosing elective cesareans and also high rates of medical intervention in childbirth, which can lead to emergency cesareans.³³ Once an intervention is introduced, the likelihood for more interventions and the risk of a woman needing a cesarean section increases dramatically.³⁴ Medical

22. SAKALA & CORRY, *supra* note 16, at 10.

23. AMNESTY INT'L, *supra* note 1, at 1; SAKALA & CORRY, *supra* note 16, at 11.

24. AMNESTY INT'L, *supra* note 1, at 4–5; SAKALA & CORRY, *supra* note 16, at 2.

25. SAKALA & CORRY, *supra* note 16, at 15.

26. CHILDBIRTH CONNECTION, AVERAGE FACILITY LABOR AND BIRTH CHARGE BY SITE AND METHOD OF BIRTH, ARIZONA, 2008–2010, at 1 (2012), <http://transform.childbirthconnection.org/wp-content/uploads/2012/05/Arizona.pdf>.

27. SAKALA & CORRY, *supra* note 16, at 15.

28. Nell Lake, *Labor Interrupted: Cesareans, “Cascading Interventions,” and Finding a Sense of Balance*, HARV. MAG., Nov.–Dec. 2012, at 21, <http://harvardmagazine.com/2012/11/labor-interrupted>.

29. *Id.*

30. *Id.*; AMNESTY INT'L, *supra* note 1, at 133 n.296 (noting that most recent recommendation by WHO in 2009 was for cesarean rates to be between 5% to 15% to decrease maternal mortality).

31. See AMNESTY INT'L, *supra* note 1, at 78.

32. SAKALA & CORRY, *supra* note 16, at 3.

33. *Id.* at 38.

34. *Id.*

interventions include rupturing of membranes, chemical induction using Pitocin or prostaglandins, and continuous fetal monitoring.³⁵ Often times these interventions are used without a medical need and with no assessment or conversation with the mother about the possible complications.³⁶ Some interventions even began to be commonly used with no prior research of the risks associated with the procedure.³⁷ Unnecessary medical interventions only complicate birth and labor and can lead low-risk women to the need for a cesarean.

Another possible reason for high medical intervention levels is the lack of use of low-risk interventions. Such underused interventions include manual maneuvering of a baby in the breech position.³⁸ The current medical practice in the United States is to schedule a cesarean if the baby is in a breech position at the mother's estimated due date or at the start of labor.³⁹ Before 1970, the majority of breech babies were born vaginally either in a breech position or after being manually turned, but now most doctors automatically schedule a cesarean even though it might not be best for mother or baby.⁴⁰ Due to this change in practice, the maneuver for turning breech babies is no longer taught in U.S. medical schools.⁴¹ Lay midwives in Tennessee run one of the few places in the United States where maternity care providers still know how to deliver breech babies.⁴² Other under-utilized labor interventions include a continual labor companion for the mother, such as a doula, and remaining upright and walking during labor, rather than lying flat in a bed.⁴³ Too heavy a reliance on medical intervention during pregnancy and childbirth puts mothers and children at risk.

35. *See id.* at 36–38, 48–49 (explaining that continuous fetal monitoring can increase the use of further interventions because changes in fetal heartbeat can be misinterpreted as fetal distress).

36. *Id.* at 7; Rachel Nall, *Risks of Fetal Monitoring*, HEALTHLINE, <http://www.healthline.com/health/pregnancy/risks-fetal-monitoring> (last visited Mar. 11, 2017) (explaining that unnecessary fetal monitoring can lead to false positive results of fetal distress causing medical professionals to perform cesareans unnecessarily).

37. SAKALA & CORRY, *supra* note 16, at 35.

38. *Id.* at 48, 51–56.

39. Lawrence M. Leeman & Lauren A. Plante, *Patient-Choice Vaginal Delivery?*, 4 ANNALS FAM. MED. 265, 266 (2006).

40. *Id.* at 265–66.

41. *See* Lake, *supra* note 28, at 22; *C-section Basics: Why is the C-section Rate in the United States so High?*, CHILDBIRTH CONNECTION, <http://www.childbirthconnection.org/giving-birth/c-section/basics/> (last visited Feb. 25, 2017).

42. Shapiro, *supra* note 3.

43. SAKALA & CORRY, *supra* note 16, at 5.

Another significant problem is lack of access to maternity care providers. Currently in the United States, the number one provider of maternal care is a medical doctor specializing in obstetrics.⁴⁴ Pregnancy is the only natural condition that is treated by a specialist rather than a primary care physician.⁴⁵ Most doctors are located in large cities near large hospitals leaving the population in rural communities largely underserved.⁴⁶ Some women must drive hours to see a doctor while pregnant and have even more limited access to specialized obstetricians should the need arise.⁴⁷ A report by Amnesty International details horrific incidents of women not getting the routine care they needed during pregnancy and subsequently suffering complications that could have been prevented or treated effectively if diagnosed early.⁴⁸ Many women do not have access to prenatal care due to their distance from facilities, high costs, lack of coverage, and sometimes even insensitivity of the care providers they do see.⁴⁹ One story details a woman being left in her hospital room for hours with no care from the nurses in the hospital.⁵⁰ Another woman died from hemorrhages due to low response time of hospital personnel; her death may have been preventable if she had received proper care.⁵¹

Another factor that may contribute to poor maternity outcomes in the U.S. is lack of knowledge by the mothers themselves.⁵² While many organizations try to help educate women about their options, the message does not always reach the intended audience because the information must be sought out by women rather than provided to them.⁵³ Most women rely on their doctors for

44. See AMNESTY INT'L, *supra* note 1, at 62–65.

45. See *id.* at 80 (“In many countries midwives or family practitioners are the usual maternal care providers for low-risk pregnancies, and specialist doctors—obstetricians—are asked to step in only in high-risk cases and in cases where complications develop unexpectedly. In contrast, in the USA, although 83 percent of women have low-risk pregnancies, the vast majority receive care from obstetricians and only 8 percent are attended in childbirth by a midwife.”); see also SAKALA & CORRY, *supra* note 16, at 62.

46. AMNESTY INT'L, *supra* note 1, at 62.

47. *Id.* at 48.

48. *Id.* at 35.

49. *Id.* at 38, 47–48, 51.

50. *Id.* at 21.

51. *Id.* at 75.

52. SAKALA & CORRY, *supra* note 16, at 35 (“It is challenging for childbearing women to recognize that structure and process of care affect outcome; to gain access to full, high-quality information and learn about benefits and harms of common and consequential labor interventions, and of alternative measures; and to clarify their preferences, set goals, and make plans for achieving their goals.”).

53 See generally CHILDBIRTH CONNECTION, <http://www.childbirthconnection.org> (last visited Feb. 25, 2017); *Push for Your Baby*, LAMAZE INT'L,

guidance and sometimes sadly, the doctors are worried about getting sued or the next event on their social calendar.⁵⁴ Hospital policies also require unnecessary interventions even without research to support such use.⁵⁵ Questions are not often welcomed from doctors or hospitals so even the women that know what to ask are not respected and given all the information they need to make truly informed decisions.⁵⁶

III. THE FIELD OF MIDWIFERY

Midwifery has been around for thousands of years but is recently seeing a resurgence as the number of women in the U.S. seeking to birth at home with a midwife is increasing.⁵⁷ Midwives focus on pregnancy and childbirth as a natural process that should only be interfered with when problems arise.⁵⁸ Pregnancy research has produced many positive advancements, such as the importance of prenatal vitamins and proper nutrition, the effects of smoking and alcohol on a developing baby, and the ability to save both mother and baby with emergency procedures.⁵⁹ Still, the low intervention approach of midwifery has its advantages and should not be discarded merely because science has found new ways to do it: new is not always better.

Midwifery is woman-focused and provides for more follow-up care than obstetricians. Midwives routinely operate out of private offices and assist women during labor either in free-standing birth centers or in the comfort of the mother's home.⁶⁰ Midwives have much lower overhead than hospitals and pass the savings onto their clients.⁶¹ Despite the lower costs of care, midwives are not ill-equipped for the job.⁶²

<http://www.lamaze.org/PUSHFORYOURBABY> (last visited Feb. 25, 2017); *Why at Least 39 Weeks is Best for Your Baby*, MARCH OF DIMES, <http://www.marchofdimes.org/pregnancy/why-at-least-39-weeks-is-best-for-your-baby.aspx> (last visited May 22, 2017).

54. See AMNESTY INT'L, *supra* note 1, at 63; SAKALA & CORRY, *supra* note 16, at 44.

55. SAKALA & CORRY, *supra* note 16, at 35. See generally LAMAZE INT'L, *supra* note 53.

56. AMNESTY INT'L, *supra* note 1, at 23; SAKALA & CORRY, *supra* note 16, at 35.

57. See generally MARIAN MACDORMAN ET AL., NAT'L CTR. HEALTH STATISTICS, DATA BRIEF NO. 84, HOMEBIRTHS IN THE UNITED STATES 1990–2009, at 5 (2012) (summarizing the 29% increase of homebirths from 2004 to 2009 in the United States as determined from birth certificates listing place of birth).

58. *What is a Midwife?*, MIDWIVES ALL. N. AM., <https://mana.org/about-midwives/what-is-a-midwife> (last visited Feb. 26, 2017).

59. SAKALA & CORRY, *supra* note 16, at 52; see also AMNESTY INT'L, *supra* note 1, at 6, 63.

60. MIDWIVES ALL. N. AM., *supra* note 58.

61. AMNESTY INT'L, *supra* note 1, at 60.

62. SAKALA & CORRY, *supra* note 16, at 62–63.

Two well-known organizations that help provide certification and continuing education for direct-entry and certified midwives in the U.S. are The North American Registry of Midwives (NARM) and Midwives' Alliance of North America (MANA).⁶³ These organizations provide support and education for current midwives and those who want to become midwives.⁶⁴ The organizations also provide information for women seeking midwifery care and offer support for women that want to push for legislation in their state to allow midwives to practice and help improve care.⁶⁵ Midwives in the U.S. can also utilize the wealth of information from international organizations that support access to midwifery care for all women.⁶⁶

A. Types and Training of Midwives

All practicing midwives receive some sort of training and education in the care of pregnant women and their newborns.⁶⁷ This training can be formal and include graduate degrees or can be self-directed.⁶⁸ For instance, Certified Nurse Midwives are trained medical nurses with advanced training in midwifery while traditional midwives learn from other experienced midwives and receive no formal licensure or certification.⁶⁹ Traditional midwives feel midwifery is a social contract and should not be legislated because women have a right to choose the care provider they are most comfortable with regardless of legal status.⁷⁰

In between these two extremes are certified midwives (CM), certified professional midwives (CPM) and direct-entry midwives (DEM).⁷¹ Certified midwives are trained in midwifery and are certified by meeting the standards

63. MIDWIVES ALL. N. AM., <https://mana.org> (last visited Feb. 26, 2017); N. AM. REGISTRY MIDWIVES, <http://narm.org> (last visited Feb. 26, 2017).

64. *About MANA*, MIDWIVES ALL. N. AM., <https://mana.org> (last visited Feb. 26, 2017); *About NARM*, N. AM. REGISTRY MIDWIVES, <http://narm.org> (last visited Feb. 26, 2017).

65. *About MANA*, *supra* note 64; *About NARM*, *supra* note 64.

66. MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS FOR THE ART AND PRACTICE OF MIDWIFERY (2005) [hereinafter MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS], <https://mana.org/pdfs/MANASStandardsQualificationsColor.pdf>.

67. *Midwifery Education*, MIDWIVES ALL. N. AM., <https://mana.org/about-midwives/midwifery-education> (last visited Feb. 26, 2017).

68. *Id.*

69. *Become a Midwife*, MIDWIVES ALL. N. AM., <https://mana.org/resources/become-a-midwife> (last visited Feb. 26, 2017).

70. *Legal Status of U.S. Midwives*, MIDWIVES ALL. N. AM., <https://mana.org/about-midwives/legal-status-of-us-midwives> (last visited Feb. 26, 2017).

71. *Id.*

of the American College of Nurse-Midwives.⁷² Certified Professional Midwives are independent professionals trained in midwifery who have met the standards of certification set forth by NARM.⁷³ A CPM is the only certification that requires knowledge and experience in out-of-hospital settings.⁷⁴ Finally, a DEM is an independent practitioner trained through self-study, apprenticeship, a midwifery school, or a college or university.⁷⁵ No matter the training path, competent midwives have the knowledge and experience to assist women through pregnancy and childbirth.

One leader in the midwifery movement is Ina May Gaskin.⁷⁶ Mrs. Gaskin is not a formally trained midwife, and yet she is the only non-medical professional to have a medical procedure named after her.⁷⁷ Mrs. Gaskin began her journey to midwifery after a traumatic hospital birth experience.⁷⁸ She began to teach herself and others about the profession in the 1960s while traveling the country with her husband and other young couples.⁷⁹ She and the other women did not have health insurance but were having babies anyway.⁸⁰ In her long career she has become a champion for natural birth and raising awareness for the many women lost in childbirth in our country.⁸¹

The numbers from her practice at the Farm prove her successes. The Farm is a farm in Tennessee where Mrs. Gaskin and the other self-trained midwives eventually settled.⁸² They continue to practice in this community, welcoming anyone who visits.⁸³ As the national cesarean rate rose from 5.5% in the 1970s to 32.8% in 2011, the rate at the Farm has remained below 3% with no maternal mortalities.⁸⁴ And while even mothers at the Farm have experienced

72. *Id.*; *Essential Facts about Midwives*, AM. COLL. NURSE-MIDWIVES, <http://www.midwife.org/Essential-Facts-about-Midwives> (last visited Feb. 26, 2017).

73. *Become a Midwife*, *supra* note 69; *What Is a CPM*, N. AM. REGISTRY MIDWIVES, <http://narm.org> (last visited Feb. 26, 2017).

74. *Become a Midwife*, *supra* note 69; *What Is a CPM*, *supra* note 73.

75. *Become a Midwife*, *supra* note 69.

76. *Biography*, INA MAY GASKIN, <http://inamay.com/biography> (last visited Feb. 26, 2017).

77. Shapiro, *supra* note 3 (“[Ina May Gaskin] is the only midwife to have an obstetric procedure named for her.”).

78. *Id.*

79. *Id.*

80. *Id.* (“Lawsuits aren’t an issue in Gaskin’s world. Her midwifery clinic has never purchased malpractice insurance or been sued. For years, when the commune was a true collective, she did not even accept payment for attending births.”).

81. *See id.*

82. *Our History*, THE FARM MIDWIFERY CTR., <http://thefarmmidwives.org/our-history/> (last visited Mar. 12, 2017).

83. *Id.*

84. Ina May Gaskin, *Reducing Fear of Birth in U.S. Culture: Ina May Gaskin at TEDxSacramento*, at 10:49, 11:41, 11:44, YOUTUBE (July 16, 2013),

loss, the infant mortality rate at the Farm has been lower than the national average for over three decades.⁸⁵ The births assisted at the Farm include breech births, multiple births, and older mothers, conditions usually considered high-risk by the medical community.⁸⁶ The practice and teachings of Mrs. Gaskin give a glimpse into what is possible when mothers are assisted in childbirth rather having the process dictated and decided for them.

B. *The Midwifery Model of Care*

No matter the training path, all midwives respect the natural process of birth and follow the midwifery model of care.⁸⁷ The midwifery model of care respects the woman as the ultimate decision-maker in the birthing process while providing her with information and guidance to ensure a healthy pregnancy and safe birth.⁸⁸ This model of care includes monitoring the physical and emotional well-being of the mother throughout the pregnancy and postpartum period.⁸⁹ It provides the mother with education and continuous hands-on support with minimal technological interventions.⁹⁰ And it also provides for identifying and referring the mother for obstetrical care when necessary.⁹¹ A woman who sees a midwife following the midwifery model of care can expect respectful treatment, personal attention, lots of information, appropriate monitoring, a newfound or renewed confidence in her body, and natural techniques for comfort.⁹²

While each organization involved in midwifery training and support has differing standards for the daily practice of a midwife, they all support a professional environment that supports the woman, her family, and the community, proving that midwives are trained professionals that do not need

<https://www.youtube.com/watch?v=S9LO1Vb54yk> (illustrating the national cesarean rate at only 5.5% in the 1970s then jumping to 20% in the 1980s and now as high as 32.8% in 2011).

85. *Id.* at 12:36. In the 1970s, the rate of infant mortality at the Farm was 2/1000 while the national rate was 11 to 15/1000. *Id.* In the 1990s, the infant mortality rate at the Farm was 2.6/1000 versus 5.8/1000 in the United States. *Id.* And from 2000 to 2013 the rate at the Farm was 0/1000 versus 4.5/1000 nationwide. *Id.* On the Farm, the midwives assist with breech births, multiples, VBACs, older mothers, and mothers with a large number of children. *See id.*

86. *Id.*

87. Lake, *supra* note 28; *The Midwives Model of Care*, CITIZENS FOR MIDWIFERY, <http://cfmidwifery.org/mmoc/define.aspx> (last visited Mar. 12, 2017).

88. *Text of the Midwives Model of Care Brochure*, CITIZENS FOR MIDWIFERY, http://cfmidwifery.org/mmoc/brochure_text.aspx (last visited Mar. 12, 2017).

89. *Id.*

90. *Id.*

91. *Id.*

92. *Id.*

to be hyper-regulated by individual states.⁹³ One example of such standards is the MANA Standards and Qualifications for the Art and Practice of Midwives.⁹⁴ The final document references six different sources including scientific publications, state regulations, and international studies on midwifery care.⁹⁵ The standards include necessary abilities of midwives, record keeping and data collection, useful equipment, complying with local regulations, and collaborating with medical professionals.⁹⁶ MANA also requires informed choice for all clients while ultimately respecting the woman's role as sole decision-maker, even if that requires discontinuing care because the midwife is asked to perform something outside of her skill set.⁹⁷ Lastly, MANA encourages continuing education, peer review of cases, and expanding the midwife's scope of practice outside of the MANA standards as the midwife sees fit.⁹⁸ The MANA standards provide a framework for a midwife's work without confining the work to rigid numerical requirements that may not cause the same complications for each woman.⁹⁹

C. Midwifery Fosters Better Relationships Between Mother and Caregiver than the Medical Model

The model of midwifery care provides for more interaction between client and midwives.¹⁰⁰ When women feel supported and connected they are more likely to ask questions and have possible issues addressed quickly and safely.¹⁰¹ The woman who has a baby at a hospital is discharged after a couple of days and does not normally see her doctor again until her six-week postpartum appointment.¹⁰² This model can lead to complications going unnoticed and becoming deadly.¹⁰³ With midwifery care, the woman is visited or contacted by the midwife in her home several times in the first week.¹⁰⁴

93. See, e.g., MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS, *supra* note 66 (describing skills, qualifications, and core competencies for midwives).

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *See id.*

100. AMNESTY INT'L, *supra* note 1, at 80; *see also* Lake, *supra* note 28.

101. AMNESTY INT'L, *supra* note 1, at 80.

102. *Id.* at 82.

103. *Id.*

104. Interview with Pamela Qualls, Licensed Midwife, CPM (Mar. 10, 2015). Mrs. Qualls is a licensed midwife in the state of Arizona. She is also certified by the North American Registry of Midwives as a Certified Professional Midwife. She has practiced for over eighteen years as a

She has a follow-up appointment at two weeks and then goes for her final appointment at six weeks just as with an OB.¹⁰⁵ These extra points of contact help a woman to feel more comfortable reaching out and help the midwife to assess the recovery of the mother as well as development of the newborn.

Midwives can also serve as an advocate for women who are or become high risk during their pregnancies. With an established relationship, a midwife can encourage a mother to seek care with a specialist.¹⁰⁶ A midwife can explain to her client the need for medical intervention from a place of trust and respect. The same information from a doctor may come off as frightening or unnecessary even when it truly is in the best interest of the mother and baby. It is in this place of trust and respect for the client and her wishes that midwifery care shows its superiority to the current medical model of maternity care in a hospital environment.

Because midwifery care respects the mother as decision-maker in the birthing process, it also allows the mother to make truly informed decisions at all critical points of her care.¹⁰⁷ Women need to have the opportunity not only to consent and refuse medical treatment but also to seek the treatment with which they are most comfortable. Informed consent and the right of refusal of medical treatment are hallmarks of the liberties we enjoy in the United States and have been upheld by the Supreme Court on numerous occasions.

IV. THE FOURTEENTH AMENDMENT PROTECTS WOMEN'S AUTONOMY AND BODILY INTEGRITY IN MAKING MEDICAL DECISIONS

Courts have held that family matters should remain free from government interventions.¹⁰⁸ Under similar reasoning, courts have upheld the right of a

midwife and has attended more than 800 births. She explained her standard of practice during the postpartum period with a mother; after leaving the home of the mother at least two hours after the birth, Mrs. Qualls will speak to the mother by phone within twelve hours of the birth. Mrs. Qualls will then perform a home visit to check on the mother and baby within seventy-two hours of the birth. The mother will go to Mrs. Qualls' office two weeks after the birth, and the final visit will occur before the six-week cutoff instituted by the state of Arizona. Mrs. Qualls is always available by phone for an emergency situation and is reachable by phone or text for minor questions. Mrs. Qualls has a good working relationship with many OBs and CNMs in the Phoenix area and does not hesitate to consult with these professionals when necessary.

105. *Id.*

106. MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS, *supra* note 66.

107. *See id.*; *see also Text of the Midwives Model of Care Brochure, supra* note 88.

108. *See generally* Troxel v. Granville, 530 U.S. 57, 65 (2000) (recognizing the fundamental right of parents to care for their children as they see fit to be one of the oldest rights recognized by the Court).

competent person to refuse medical treatment for any reason.¹⁰⁹ This right has even been protected when a third party is involved and lack of intervention could cause the death of the third party.¹¹⁰ Yet, when a mother wants to refuse a cesarean section against a doctor's recommendation, courts do not always follow the precedent that allows a woman to refuse medical intervention.¹¹¹ In fifteen cases of hospitals taking mothers to court in an attempt to force cesareans, thirteen courts have sided with the hospital.¹¹² A mother's right to refuse medical treatment should be no different than that of any other competent individual.¹¹³ When hospitals use the court system to force patients to undergo medical treatment, patients begin to lose trust in both the medical system and the legal system.¹¹⁴

In some of the cases of hospitals trying to force women into cesareans, the woman has escaped the hospital and delivered a healthy child vaginally.¹¹⁵ This is due in part because the medical community is fallible and no diagnosis is an absolute.¹¹⁶ Because of the rapid nature of such situations only a few of these cases have gone onto an appellate court.¹¹⁷ In two such cases, the courts have held that a woman's constitutional rights should not be less important than the rights of her unborn child and that no balancing tests of whose rights are more important should be done because the woman's right to take care of

109. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990).

110. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91–92 (Ct. C.P. 1978).

111. Veronika E.B. Kolder, Janet Gallagher & Michael T. Parsons, *Court-Ordered Obstetrical Interventions*, 316 NEW ENG. J. MED. 1192, 1192 (1987).

112. *In re A.C.*, 573 A.2d 1235, 1243 (D.C. Cir. 1990) (citing Kolder, Gallagher & Parsons, *supra* note 111, at 1192).

113. See *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring) ("Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.").

114. See generally COMM. ON ETHICS, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, COMMITTEE OPINION NO. 321, MATERNAL DECISION MAKING, ETHICS, AND THE LAW (2005) [hereinafter MATERNAL DECISION MAKING]; Paul Burcher, *What's an Ethical Response to Home Birth?*, OBGYN.NET BLOG (Dec. 4, 2014), <http://www.obgyn.net/pregnancy-and-birth/whats-ethical-response-home-birth?cid=jointheconversation&GUID=DBD8F681-371F-4E98-81B1-CC467116FF42&XGUID&rememberme=1&ts=11122014>.

115. *In re Baby Boy Doe*, 632 N.E.2d 326, 329 (Ill. App. Ct. 1994) (explaining that mother did deliver a healthy baby boy naturally despite grim prognosis by doctors); MATERNAL DECISION MAKING, *supra* note 114, at 2.

116. MATERNAL DECISION MAKING, *supra* note 114, at 5 (advising physicians that they must give a balanced evaluation of the health of both mother and child since medical knowledge is limited and not always correct in predicting outcomes).

117. See generally *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr. Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); *In re A.C.*, 573 A.2d 1235, 1237 (D.C. 1990); *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981); *In re Baby Boy Doe*, 632 N.E.2d at 329.

her family is also protected by the Constitution.¹¹⁸ However, other courts have held that the State's interest to protect the child outweighs the constitutional rights of the mother.¹¹⁹

Cases supporting a woman's right to refuse medical treatment during pregnancy have been decided in Illinois and Washington D.C.¹²⁰ In *In re Baby Boy Doe*, Doe, the mother, had been receiving prenatal care throughout her first pregnancy.¹²¹ At thirty-five weeks gestation, it was discovered that her unborn child may not be receiving adequate oxygen due to a problem with the placenta.¹²² The doctor recommended either an immediate cesarean section or inducement of labor.¹²³ The doctor informed Doe and her husband of the risks involved by refusing the treatment.¹²⁴ With full knowledge of the risks, Doe and her husband refused a cesarean section.¹²⁵ The doctor and hospital then contacted the Cook County State's Attorney seeking to gain custody of the unborn child in order to force Doe to have a cesarean.¹²⁶ The State also asked the court to balance the rights of the unborn child against the rights of Doe, the child's mother.¹²⁷ After denying the State's request for custody of the unborn child, the court held that courts should not balance the rights of an unborn child against the rights of its mother and a "woman's competent choice in refusing medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus."¹²⁸

The court based its decision in part on the decision by the U.S. Supreme Court in *Cruzan by Cruzan v. Director, Missouri Department of Health*.¹²⁹ In *Cruzan*, the Supreme Court noted that individuals have "a constitutionally

118. *In re A.C.*, 573 A.2d at 1247 (explaining that the trial court erred in balancing rights of mother against rights of child); *In re Baby Boy Doe*, 632 N.E.2d at 329 (finding no precedent requiring a balancing of rights of mother with rights of child).

119. *Pemberton*, 66 F. Supp. 2d at 1251 (holding that the personal constitutional rights of mother did not outweigh State's interest in protecting life of unborn child); *Jefferson*, 274 S.E.2d at 460 (finding that State interest in the life of the unborn child outweighs physical intrusion against mother).

120. *In re A.C.*, 573 A.2d at 1247; *In re Baby Boy Doe*, 632 N.E.2d at 326.

121. 632 N.E.2d at 326.

122. *Id.* at 327.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* at 327–28.

127. *Id.* at 330.

128. *Id.*

129. *Id.* at 331; see *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 287 (1990) (O'Connor, J., concurring).

protected liberty interest in refusing unwanted medical treatment.”¹³⁰ In her concurrence, Justice O’Connor went on to explain that the liberty guaranteed by the Due Process Clause must protect an individual’s decision to refuse medical treatment “[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state intrusions into the body repugnant to the interests protected by the Due Process Clause.”¹³¹

The court in *Doe* cited the intensity and risk of the cesarean section as one reason for the court to not order it against a woman’s will.¹³² The court hinted that it may force a woman to have a blood transfusion against her will if it was necessary to the survival of her unborn child because it was only a mildly intrusive procedure.¹³³ However, in a later Illinois case, *In re Fetus Brown*, the court held that the severity of a medical procedure does not matter when being forced upon a competent adult.¹³⁴ In that case, the court allowed a pregnant mother to refuse a blood transfusion that the medical community felt was vital to the health of her child.¹³⁵

Similarly, the Massachusetts Supreme Judicial Court overruled a lower court ruling that a woman be forced to undergo a “slight” operation in order to hold her pregnancy.¹³⁶ The couple had four children and had had one miscarriage in the seventh month.¹³⁷ In the current pregnancy, the husband took his wife to court because she did not want to undergo a surgery that was deemed necessary to hold this pregnancy.¹³⁸ The Massachusetts Supreme Judicial Court held that the woman’s constitutional rights were established, and as a competent adult, the State had no interest in forcing her to undergo treatment against her will.¹³⁹

Using similar reasoning a third appellate court held that a woman’s refusal to have a cesarean section could not be used as evidence of neglect of her

130. *Cruzan*, 497 U.S. at 278 (majority opinion); *see also id.* at 304 (Brennan, J., dissenting) (“[T]he Due Process Clause of the Fourteenth Amendment confers a significant liberty interest in avoiding unwanted medical treatment.”) (citation omitted).

131. *Id.* at 288 (O’Connor, J., concurring).

132. *In re Baby Boy Doe*, 632 N.E.2d at 333.

133. *Id.* (leaving the issue of compelling a mother to have non-invasive procedures to future cases).

134. *In re Brown*, 689 N.E.2d 397, 405 (Ill. App. Ct. 1997) (disagreeing with *In re Baby Boy Doe* that a blood transfusion was a non-invasive, risk-free procedure because it still interrupted the bodily integrity of a competent adult).

135. *Id.*

136. *Taft v. Taft*, 446 N.E.2d 395, 395 (Mass. 1983).

137. *Id.* at 396.

138. *Id.*

139. *Id.* at 397.

child.¹⁴⁰ The New Jersey Superior Court, Appellate Division noted first, that despite medical opinions of the health of the unborn child, the mother did in fact deliver a healthy child vaginally.¹⁴¹ The court went on further to explain that the mother and her husband were notified of all risks associated with refusing a cesarean section.¹⁴² They were therefore making an informed refusal to consent.¹⁴³ The court concluded that the decision to undergo an invasive procedure rests solely with the mother after consulting with her doctors.¹⁴⁴

Courts do not only side with the mother when there is a happy ending. In *In re A.C.*, a terminally ill woman refused to have a cesarean section to save her unborn child.¹⁴⁵ The trial court overrode A.C.'s decision and ordered the cesarean.¹⁴⁶ The child died hours after the procedure.¹⁴⁷ Even after the death of A.C. and her child, the case was heard at the appellate level because the court felt that this case was not moot because the case involved an issue that would be encountered by the hospital again, and that therefore the legal issues needed to be addressed.¹⁴⁸ The appellate court upheld A.C.'s right as a competent woman to make informed medical decisions even when it may put her child at risk.¹⁴⁹ The court went through a thorough analysis of when the government can impose medical intervention on individuals, such as vaccinations and when the fitness of the mother is in question.¹⁵⁰ The appellate court ruled in this case that the district court erred by making its ruling based on the viability of the unborn child rather than using the substitute judgment of the mother.¹⁵¹

Two cases where courts have held that the State can force a woman to have a cesarean section when the health of her baby is at stake were decided in Georgia and Florida.¹⁵² In Georgia, a woman was diagnosed with placenta

140. N.J. Div. of Youth & Family Servs. v. V.M., 974 A.2d 448, 449 (N.J. Super. Ct. App. Div. 2009) (per curiam).

141. *Id.* (Carchman, J., concurring).

142. *Id.* at 451.

143. *Id.*

144. *Id.* at 464 (citing N.J. Div. of Youth & Family Serv. v. L.V., 889 A.2d 1153, 1157–58 (N.J. Super. Ct. Ch. Div. 2005)).

145. *In re A.C.*, 573 A.2d 1235, 1238 (D.C. 1990).

146. *Id.* at 1237.

147. *Id.* at 1238.

148. *Id.* at 1241.

149. *Id.* at 1247.

150. *Id.* at 1245.

151. *Id.* at 1252.

152. See generally *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr. Inc.*, 66 F. Supp. 2d 1247 (N.D. Fla. 1999); *Jefferson v. Griffin Spalding Cty. Hosp. Auth.*, 274 S.E.2d 457 (Ga. 1981).

previa, a condition in which the placenta blocks the birth canal so that the child cannot be delivered vaginally.¹⁵³ The trial court first ordered that the hospital could perform the cesarean against the mother's wishes only if she voluntarily presented herself to the hospital for assistance in the birth.¹⁵⁴ Because of the viability of the unborn child, the court then granted the State of Georgia Department of Human Resources and the Butts County Department of Family and Children Services temporary custody of the unborn child.¹⁵⁵ The mother was then ordered to present herself to the hospital for an ultrasound in order for doctors to determine whether the placenta previa was still blocking the birth canal.¹⁵⁶ If the placenta was still in the way, then the mother would be required to have a cesarean section against her wishes.¹⁵⁷ The court based its decision in part on *Roe v. Wade*,¹⁵⁸ claiming that a viable unborn child has the constitutional right to the protection of the State from an arbitrary abortion.¹⁵⁹ However, the mother had no intention of terminating her pregnancy; she wished only to have her child naturally and had the hope and faith that it was possible even if she was the only one that believed it.¹⁶⁰ She was exercising her constitutional right to refuse medical treatment as any other individual has the right to do.¹⁶¹

Similarly, in a Florida case, a woman sought to utilize her constitutional right to refuse medical treatment, but was denied.¹⁶² The woman was expecting her first child since having undergone a cesarean section the previous year.¹⁶³ She attempted to find a doctor that would allow her to attempt a vaginal delivery but was unable to.¹⁶⁴ She then prepared to have a homebirth attended by a midwife.¹⁶⁵ After more than a day of labor she presented herself to the hospital to get intravenous (IV) fluids because she could not hold down any food or water, and she would need nourishment to have the strength to deliver her child naturally.¹⁶⁶ She did not withhold her

153. *Jefferson*, 274 S.E.2d at 458.

154. *Id.*

155. *Id.* at 459.

156. *Id.* at 459–60.

157. *Id.* at 460.

158. 410 U.S. 113 (1973).

159. *Jefferson*, 274 S.E.2d at 458.

160. *Id.*

161. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 277 (1990).

162. *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1249–50 (N.D. Fla. 1999).

163. *Id.* at 1249.

164. *Id.*

165. *Id.*

166. *Id.*

plans from the doctor who examined her and was punished for her honesty.¹⁶⁷ The doctor did not give her the requested IV fluids but instead notified the hospital of the situation.¹⁶⁸ She and her husband left the hospital and returned home.¹⁶⁹ The hospital set in motion an established procedure to request a court order for anyone refusing medical treatment.¹⁷⁰ Ms. Pemberton's will was overridden and a cesarean section was performed to deliver her healthy baby boy.¹⁷¹

She and her husband then requested damages against the hospital in district court.¹⁷² She based her claim on her "right to bodily integrity, a right to refuse unwanted medical treatment, and a right to make important personal and family decisions regarding the bearing of children without undue governmental interference."¹⁷³ The district court denied Ms. Pemberton's request for damages holding that her individual constitutional rights "did not outweigh the interests of the State in preserving the life of an unborn child."¹⁷⁴ The court used the same reasoning as the Georgia court above, citing *Roe v. Wade*.¹⁷⁵ The court tried to negate the difference between a woman wanting to abort a viable unborn child, as provided by in *Roe*, and a woman refusing medical treatment that may cause the death of a child, by saying that because the end result could be the same, the intent of the woman did not matter.¹⁷⁶ However, this logic does not follow because in the first situation, the death of the child is definite whereas in the second situation, death even against the strongest of medical opinions is only a possibility.¹⁷⁷ Secondly, in numerous areas of the law it is precisely the intent of the actor that creates liability, whether civil or criminal.¹⁷⁸ Even the Catholic teachings against aborting a child make a distinction as to the intent of the actions. Removing diseased

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.* at 1249–50.

171. *Id.* at 1250.

172. *Id.*

173. *Id.* at 1251.

174. *Id.*

175. *Id.*

176. *Id.* at 1251 n.9.

177. MATERNAL DECISION MAKING, *supra* note 114, at 5 (explaining that doctors should not use the court system to override a woman's informed refusal because even medical science is fallible).

178. RESTATEMENT (THIRD) OF TORTS: GEN. PRINCIPLES § 1 DD (AM. LAW INST. 1999) ("An actor's causation of harm is intentional if the actor brings about that harm either purposefully or knowingly."); 22 C.J.S. *Criminal Law* § 37 ("A person does not commit a crime who commits the act or makes the omission charged through misfortune or by accident, when it appears that there has been no evil design, intention, or culpable negligence.").

tissue which also contains a viable fetus is licit because the intent is to save the mother's life, not to end the life of the child.¹⁷⁹ A mother's wish to forgo medical treatment does not mean she wishes to harm her child.

The district court then differentiated *Roe* and a woman refusing medical treatment in detriment to her unborn child by stating that raising an unwanted child is more intrusive than having a surgery against one's will.¹⁸⁰ Again, this logic does not follow the conclusion the court would like it to as evidenced by the fact that the Supreme Court and other lower courts have held that a competent person should not be subjected to an unwanted medical treatment.¹⁸¹ ACOG has written an ethics opinion warning against forcing mothers to submit to unwanted medical treatment.¹⁸² Similarly, there are many cases of women describing extreme mental anguish due to treatment in hospitals during labor, which continued to affect their mental health for years to come.¹⁸³ Based on these outcomes, the district court in Florida should have followed the reasoning in *Thornburgh v. American College of Obstetricians and Gynecologists*, wherein the Supreme Court held it was unconstitutional for a statute to require a trade-off between a mother's health and that of her child, any increased risk to the mother's health is unacceptable.¹⁸⁴

By extension, if women have the constitutional right to decline treatment, they should also be able to seek the treatment they want. If a woman is allowed to seek the treatment that makes her the most comfortable and provides for the best outcomes she will not need to later assert her right to refuse medical treatment because she has asserted her right to choose her care. The right to choose care is just as important and foundational as the right to refuse care.

Furthermore, the risks from which states are so desperate to save a woman and her unborn child are not risks at all. Research of evidence-based care is

179. Edwin F. Healy, *Indirect Abortion*, ETERNAL WORD TELEVISION NETWORK: GLOBAL CATHOLIC NETWORK, <https://www.ewtn.com/library/PROLIFE/INDIRECT.TXT> (last visited May 3, 2017) ("There is no direct attack upon the fetus, however, and its death is merely permitted as a secondary effect of an act which needs to be performed and which, as we shall see immediately, it is permissible to perform.").

180. *Pemberton*, 66 F. Supp. 2d at 1251 n.9.

181. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 277 (1990).

182. See generally MATERNAL DECISION MAKING, *supra* note 114.

183. See generally Jennifer J. Griebenow, *Healing the Trauma: Entering Motherhood with Posttraumatic Stress Disorder (PTSD)*, MIDWIFERY TODAY, Winter 2006, http://www.midwiferytoday.com/articles/healing_trauma.asp.

184. *In re Baby Boy Doe*, 632 N.E.2d 326, 333 (Ill. App. Ct. 1994) (citing *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986), *overruled by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (holding that balancing the rights of the fetus against the health of the mother is unconstitutional)).

increasingly showing that less intervention is better, and homebirths are as safe as hospital births.¹⁸⁵

V. THE SAFETY OF HOMEBIRTHS IS PROVEN BY SCIENTIFIC RESEARCH STUDIES

Given the current state of maternal care in the U.S., it is good public policy to allow and encourage woman to seek out care from a midwife for prenatal, labor, and postpartum care. With more women seeing midwives there will be an opportunity to build on the current research on the safety of midwifery care. The safety of homebirths has already been analyzed both internationally and domestically.¹⁸⁶ All well-conducted studies show that there is no increased risk of death of mother or baby when a mother chooses to have a homebirth assisted by a trained midwife.¹⁸⁷

We as a country should look to countries that have greater success in taking care of mothers and infants and see what they are doing. The United States is the only industrialized nation that does not offer midwifery as the primary care option for low risk women.¹⁸⁸ One country with low maternal death rates is the Netherlands, with an annual maternal mortality rate of less than seven mothers per 100,000 births in the country.¹⁸⁹ In the Netherlands, thirty percent of mothers give birth at home with a trained midwife.¹⁹⁰ The Netherlands has a two-tiered system for maternity care; low-risk women see a midwife and can choose to birth either at home or in a hospital, and women with complications or higher risks for complications are referred to an obstetrician.¹⁹¹ The seven-year study of over 500,000 births done in the Netherlands shows that giving birth at home with a trained midwife is equally safe as giving birth in a hospital for low-risk women.¹⁹²

185. SAKALA & CORRY, *supra* note 16, at 4, 8–9; de Jonge et al., *supra* note 10, at 1177.

186. *See generally* Cheyney et al., *supra* note 10, at 17; de Jonge et al., *supra* note 10, at 1177; Janssen et al., *supra* note 10, at 377.

187. *Compare* Cheyney et al., *supra* note 10 (taking the values for its studies directly from practitioners and clients), *and* de Jonge et al., *supra* note 10 (same), *and* Janssen et al., *supra* note 10 (same), *with* Joseph Wax et al., *Maternal and Newborn Outcomes in Planned Home Birth vs. Planned Hospital Births: A Metaanalysis*, 203 AM. J. OBSTETRICS & GYNECOLOGY 243 (2010) (undertaking a meta-analysis that took its values from birth certificates and older studies).

188. AMNESTY INT'L, *supra* note 1, at 81.

189. WORLD HEALTH ORGANIZATION, *supra* note 8, at 26.

190. de Jonge et al., *supra* note 10, at 1178.

191. *Id.*

192. *Id.* at 1178, 1181.

Similarly, new recommendations have been released in the United Kingdom, which encourage women to use a midwife either at home or in a freestanding birth center.¹⁹³ The recommendations are based on lower rates of intervention and overall better outcomes for mothers and babies.¹⁹⁴ The recommendations highlight the importance of giving a woman all of the available information on her options of birthing settings so that she may make a truly informed decision.¹⁹⁵ The U.K. recommendations acknowledge the life-changing event that giving birth is for a woman and her family, and the effect that a positive birthing experience can have on the mother and baby.¹⁹⁶ It is also recommended that those taking care of the mother practice good communication, give her support and compassion and respect her wishes so that she feels in control of the situation.¹⁹⁷ In the studies cited by the recommendations, mothers giving birth at home or in a freestanding birth clinic have higher rates of spontaneous labor and lower rates of interventions than in a hospital setting whether attended by a midwife or a physician.¹⁹⁸ The outcome for the baby is no different in any of the settings.¹⁹⁹

Closer to home, a study was done in British Columbia which included not only purely low risk women but also women with breech babies and those attempting vaginal births after cesarean sections.²⁰⁰ This study focused on the planned place of birth at the beginning of the pregnancy.²⁰¹ It compared outcomes for women planning to birth at home with a registered midwife with women who planned to birth at a hospital with either a midwife or physician.²⁰² Women who planned birth at home had significantly lower rates of obstetrical interventions such as electronic fetal monitoring, augmentation of labor, assisted vaginal delivery, cesarean sections, and episiotomies.²⁰³ The homebirth mothers also had lower rates of third- and fourth-degree tears and significantly lower adverse maternal outcomes, such as infections and

193. NICE GUIDELINES, *supra* note 13, at 7.

194. *Id.* at 5 (“[P]lanning to give birth at home or in a midwifery-led unit (freestanding or alongside) is particularly suitable for them because the rate of interventions is lower and the outcome for the baby is no different compared with an obstetric unit.”).

195. *Id.* at 6.

196. *Id.* at 82.

197. *Id.* at 15.

198. *Id.* at 8.

199. *Id.*

200. Janssen et al., *supra* note 10, at 378–79.

201. *Id.* at 378.

202. *Id.*

203. *Id.* at 379.

postpartum hemorrhaging.²⁰⁴ In this study of 2,285 births done at home there were no perinatal deaths.²⁰⁵

The most recent study done in the U.S. assessing the safety of planned homebirths is the MANA Statistical Project published in 2014.²⁰⁶ The study was an observational study that analyzed the information provided by current midwives and their clients.²⁰⁷ While the best method for a scientific study is a randomized control trial, this is not possible in the study of births because most women want to choose their place and manner of birth, and are unwilling to be blindly assigned.²⁰⁸ In the MANA study, the midwife providing care, with the consent of her client, voluntarily provided the information.²⁰⁹ The results of the study included 15,079 homebirths assisted by 432 midwives of various backgrounds, including CPMs, LMs, CNMs, CMs, direct-entry unlicensed midwives and traditional midwives.²¹⁰ The MANA study, which only assessed planned homebirths assisted by trained midwives, found results similar to those of the international studies, that homebirths are just as safe as hospital births for mother and baby.²¹¹ Homebirths are also linked to lower intervention rates and lower stress levels for the mothers.²¹²

The MANA study also included VBACs (vaginal birth after cesarean) and multiple births.²¹³ For the VBACs there was an increased risk of intrapartum, during labor and delivery, fetal death when compared to multiparous, not-first-pregnancy, mothers with no history of cesareans, but there was no increase in neonatal death.²¹⁴ There was no evidence of increased risk of death among multiple births.²¹⁵

The evidence shows that homebirths are not dangerous and should be an available option to all low risk women.²¹⁶ Because the midwifery model of care already accounts for consultation and transfer of care when

204. *Id.*

205. *Id.* at 380.

206. Cheyney et al., *supra* note 10, at 17.

207. *Id.* at 18.

208. *Id.*; de Jonge et al., *supra* note 10, at 1178.

209. Cheyney et al., *supra* note 10, at 18.

210. *Id.* at 19.

211. *Id.* at 25.

212. *Id.* at 26.

213. *Id.* at 23.

214. *Id.*

215. *Id.*

216. *See generally* Cheyney et al., *supra* note 10; de Jonge et al., *supra* note 10; Janssen et al., *supra* note 10.

complications arise it is not necessary for states to overregulate the practice of midwifery or discourage women from seeking this form of care.²¹⁷

VI. ARIZONA RULES REGULATING MIDWIFERY CURRENTLY IMPOSE
UNNECESSARY RESTRICTIONS ON MIDWIVES AND PUT A STRAIN ON
THE RELATIONSHIP BETWEEN MIDWIFE AND CLIENT

Midwifery care in Arizona has been regulated by statute since the 1950s.²¹⁸ Recently with increased popularity of homebirths, clients and midwives approached the State asking for increased freedom of practice and autonomy of care.²¹⁹ Before the recent change in rules, a woman seeking a homebirth could not have had a fetus in the breech position, multiple fetuses, or previous cesarean.²²⁰ Women with these medical histories wanted homebirths but licensed midwives were not able to assist these women without putting their licenses and professional lives at stake.²²¹

When the State approved an evaluation for a change in the rules, it gave the rule making power to the Arizona Department of Health Services.²²² A Midwifery Advisory Committee was formed, consisting of four licensed midwives, one member of the public with experience using a midwife, one licensed physician, a nurse midwife, and an ex-officio member.²²³ The rules state no qualification on the background of the physician or nurse midwife; to be truly helpful to the cause of those seeking homebirths it would be best for these positions to be familiar with homebirths, either by previous witness of homebirths or significant experience consulting with a licensed midwife who attends out of hospital births.²²⁴ To have these positions filled by professionals that are staunchly opposed to out-of-hospital births will only

217. *The Midwives Model of Care*, *supra* note 87.

218. ARIZ. REV. STAT. ANN. §§ 36-751 to -760 (1957).

219. Alia Beard Rau, *Arizona Midwives Want Regulation Overhauled*, ARIZ. REPUBLIC (June 19, 2012, 9:58 PM), <http://archive.azcentral.com/news/politics/articles/2012/06/11/20120611arizona-midwives-want-regulations-overhauled.html>; Interview with Pamela Qualls, *supra* note 104 (explaining that colleagues and stakeholders (women in the community) had requested that the state legislature open the rule making process for midwifery to allow greater scope of care, particularly in VBAC and breech situations and noting that the colleagues also wanted to be able to attend births with multiple fetuses but this increase of scope was not added to the new rules).

220. Interview with Pamela Qualls, *supra* note 104.

221. *Id.*

222. ARIZ. ADMIN. CODE §§ R9-16-101 to -117 (2016) (explaining that effective 2012, the Arizona Department of Health Services is required by statute to consider adopting rules that decrease the regulatory burden on midwifery services in Arizona).

223. § R9-16-117 (outlining the requirements of the Midwifery Advisory Panel).

224. *Id.*

cause a deadlock in progress to provide women who want homebirths assisted by midwives with access to such services. Because a woman who feels strongly about having a homebirth may attempt a homebirth whether assisted or not it is better to provide her access to the care and support a trained midwife can provide rather than leaving her to fend for herself.

Medical standards, rather than the midwifery model of care, noticeably influenced the rules that were eventually approved by the advisory committee.²²⁵ While the committee was able to agree to allow women access to midwives while attempting a VBAC at home, the restrictions on the access impede the woman's right to assess the risk for herself. In the current rules, the place of birth may be no farther than twenty-five miles from a hospital that provides maternity care.²²⁶ This distance takes into account that once a woman's uterus ruptures there is only a thirty-minute window to perform a cesarean to save her and the baby.²²⁷ However, there is a difference between a uterine rupture and the more common uterine scar dehiscence, the disruption and separation of a previous uterine scar, more commonly seen in VBACs.²²⁸ The complications arising from scar dehiscence are less severe because the placenta, fetus, and umbilical cord remain inside the uterus and bleeding is not clinically significant.²²⁹ If a cesarean is deemed necessary it is likely not because of scar dehiscence because fetal distress is not associated with this complication.²³⁰

Further, this distance restriction puts a much larger burden on those women who live in rural areas. With only three major cities, Phoenix

225. §§ R9-16-108(J)(4)(c), -111(B)(19) (referencing that the ACOG active labor guidelines must be followed and if client's labor deviates from guidelines care must be transferred from midwife to hospital); Lake, *supra* note 28 (discussing that a midwife explained that doctors are quicker to intervene during labor because it is not going fast enough rather than letting nature take its course); Shapiro, *supra* note 3 (wherein Ina May Gaskin explains that they have never had a diagnosis of failure to progress because birth does not always follow the textbooks).

226. § R9-16-108(D)(2).

227. Gerard G. Nahum, *Uterine Rupture in Pregnancy*, MEDSCAPE, <http://reference.medscape.com/article/275854-overview> (last updated Mar. 25, 2016) (explaining that when a uterine rupture occurs there is only a ten to thirty-seven-minute window to perform a cesarean section before significant damage to unborn child occurs); Marsden Wagner, *What Every Midwife Should Know About ACOG and VBAC: Critique of ACOG Practice Bulletin No. 5, July 1999, "Vaginal Birth After Previous Cesarean Section,"* MIDWIFERY TODAY, <http://www.midwiferytoday.com/articles/acog.asp> (last visited Feb. 26, 2017) (noting one problem with the ACOG recommendation that VBACs only be attempted in tertiary hospitals is that cesareans can occur faster, however data shows that even in hospitals it usually takes more than thirty minutes to perform cesarean once the decision is made).

228. Nahum, *supra* note 227.

229. *Id.*

230. *Id.*

(including the metro area), Tucson, and Flagstaff, much of Arizona is considered rural.²³¹ Of the ten Level I trauma centers in Arizona, eight are in the Phoenix metro area.²³² Anyone with a significant medical emergency outside of this limited area would have to be flown into Phoenix for treatment.²³³ People living in rural areas assume this risk when they choose to live outside of big cities in Arizona.²³⁴ The voluntary assumption of this risk should not be automatically taken away from women with a history of cesarean that want a homebirth especially since it is just that, a risk, not an absolute.²³⁵ The low risk of uterine rupture for VBACs, 0.4–0.8%, for women with one previous cesarean, is generally exaggerated by comparing a woman with a previous cesarean to a woman who has no previous cesarean and only has a 0.0012% risk of uterine rupture.²³⁶ This difference is usually reported as a 300% increase in risk.²³⁷

The rules again rely too heavily on medical guidelines by specifically stating the labor must stay within the guidelines for progress of active labor according to the Management Guidelines recommended by ACOG.²³⁸ It is these guidelines that attribute to the high level of unnecessary interventions in a hospital setting.²³⁹ Women see midwives for care because they know labor does not always follow a textbook and they want to be in a setting where the power of their body to deliver their baby is respected.²⁴⁰

Another problem with the current rules is the automatic transfer of care or consultation that is triggered by certain events.²⁴¹ If a woman chooses to go

231. U.S. DEP'T AGRIC. ECON. RESEARCH SERV., ARIZONA: THREE RURAL DEFINITIONS BASED ON CENSUS PLACES (2007), https://www.ers.usda.gov/webdocs/Data-Files/53180/25557_AZ.pdf?v=39329 (showing a map of the urban clusters denoted by a dark red color which represents greater than or equal to 50,000 people in Arizona—the largest is the Phoenix metro area in Maricopa County, followed by Tucson in Pima County and Flagstaff in Coconino County).

232. *Arizona State Designated Trauma Centers*, ARIZ. DEP'T HEALTH SERVS., (Feb. 28, 2017), <http://www.azdhs.gov/documents/preparedness/emergency-medical-services-trauma-system/trauma/az-designated-trauma-centers.pdf>.

233. Interview with Pamela Qualls, *supra* note 104.

234. MATERNAL DECISION MAKING, *supra* note 114, at 5.

235. *Id.*

236. Nahum, *supra* note 227.

237. *Id.*

238. ARIZ. ADMIN. CODE § R9-16-108(J)(4)(c) (2016).

239. SAKALA & CORRY, *supra* note 16, at 74.

240. Lake, *supra* note 28 (describing a midwife who explained that doctors are quicker to intervene during labor because it is not going fast enough rather than letting nature take its course); Shapiro, *supra* note 3 (stating that Ina May Gaskin explained that they have never had a diagnosis of failure to progress because birth does not always follow the textbooks).

241. *See generally* § R9-16-108(e) to (f) (outlining the requirement that a midwife explain the requirement for transfer of care or consultation in certain situations); ARIZ. ADMIN. CODE §

to the hospital for any reason during her labor, the midwife must terminate her care and cannot see her as a client again until her next pregnancy.²⁴² Women can choose to go to the hospital during labor for any number of reasons that are not the result of medical complication, such as wanting pain medication or needing intravenous fluids due to dehydration.²⁴³ Currently the woman must stay in the hospital for these interventions until the birth of her child and is not allowed to go back to see her midwife for follow-up care.²⁴⁴ A woman in this situation has an established relationship with her midwife spanning at least nine months and no relationship with the doctor who may or may not have been present at her actual birth but is now on her medical chart.²⁴⁵ This disturbs the continuity of care that is suggested by both the midwifery model of care and medical recommendations.²⁴⁶ The doctor may simply ask for the recommendations of the midwife because she knows the client best.²⁴⁷

The requirements for consultations that are in the rules put a burden both on the midwife and the doctor or CNM with whom she is consulting.²⁴⁸ The rules currently require a midwife to consult with a doctor or CNM when the client has not gained at least twelve pounds by thirty weeks or has gained more than eight pounds in a two-week period.²⁴⁹ While weight fluctuations can be a sign of an underlying medical problem, it can also be a sign of a change in the woman's eating habits.²⁵⁰ A woman with a BMI between 25 and 29.9 is recommended to gain only fifteen and twenty pounds during pregnancy and a woman with a BMI over thirty is recommended to gain only between eleven to twenty pounds.²⁵¹ If she stays within these guidelines she may not reach the twelve pounds by thirty weeks dictated by the rule and yet she may be even healthier than when she started her pregnancy because she

R9-16-111 (2014) (giving the conditions that require the midwife to transfer care of client to a medical doctor or CNM); ARIZ. ADMIN. CODE § R9-16-112 (2014) (giving the situations in which a midwife is required to consult with a doctor or CNM).

242. Interview with Pamela Qualls, *supra* note 104.

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. *Id.*

248. *Id.*

249. ARIZ. ADMIN. CODE § R9-16-112(A)(7) (2016).

250. Interview with Pamela Qualls, *supra* note 104.

251. INST. OF MED. & NAT'L RESEARCH COUNCIL OF THE NAT'L ACADS., WEIGHT GAIN DURING PREGNANCY: REEXAMINING THE GUIDELINES 2 (Kathleen M. Rasmussen & Ann L. Yaktine eds., 2009).

has changed her eating habits and is engaging in moderate exercise.²⁵² Similarly, an eight pound weight gain in two weeks could be a sign of poor nutrition, for instance eating cheesecake or ice cream twice a day for two weeks.²⁵³ A midwife can assess the situation through her relationship with her client and specific questions and can then determine if medical care is necessary.²⁵⁴ But currently a midwife must make these assessments and still consult with a doctor knowing there is no need for alarm.²⁵⁵ This requirement undermines a midwife's training and professionalism.²⁵⁶ Further, consultation is already a standard of the midwifery model of care and does not need to be so strictly regulated by triggering events as done by the current rules.²⁵⁷

The rules also place unnecessary restrictions on a midwife's independent practice in the way they regulate usage of medication. The rules account for emergency situations and the midwife's ability to manage these emergencies with medication.²⁵⁸ However, the rules require that a midwife have standing orders from a physician in order to carry and use the medications.²⁵⁹ In other states such as New Mexico, Colorado, Maine, and Washington the midwifery regulations allow the midwife to obtain necessary medications from a pharmacist with her own license and qualifications.²⁶⁰ This allows midwives to have the medications they need to treat their clients as they see fit.

Similarly, the rules recommend administration of Vitamin K to the newborn but only under orders from a doctor.²⁶¹ Pediatricians often will not provide these orders because they do not have a patient to write a prescription for until the child is born.²⁶² Obstetricians do not prescribe this medication

252. Interview with Pamela Qualls, *supra* note 104.

253. *Id.*

254. *Id.*

255. *Id.*

256. *Id.*

257. *See* MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS, *supra* note 66, at 1.

258. ARIZ. ADMIN. CODE § R9-16-113(B) (2016).

259. *Id.*

260. COLO. REV. STAT. § 12-37-105.5 (2016) (allowing direct entry midwives to obtain specific medications directly from a registered drug outlet, manufacturer, or wholesaler); ME. STAT. tit. 32, § 12535 (2016) (listing the prescription drugs certified midwives can possess and administer directly from a licensed pharmacist); N.M. CODE R. § 16.11.3.12(A)(6) (LexisNexis 2016) (referencing the New Mexico Midwives Association Policies and Procedures for the list of specific drugs and medications that licensed midwives may carry and administer as independent health care practitioners); WASH. REV. CODE § 18.50.115 (2016) (listing drugs that licensed midwives may obtain directly from a pharmacist).

261. ARIZ. ADMIN. CODE § R9-16-108(K)(2)(c) to (d) (2016).

262. *See* Interview with Dr. Agarwal, M.D. (May 2013). The interview was a potential new client interview that I conducted while looking for a pediatrician. Dr. Agarwal responded to my question regarding the possibility of getting a prescription for Vitamin K before the birth of the

because it is administered to the child and not the mother who is the obstetrician's patient.²⁶³ In many instances, the rules provide for treatment without the proper protocol for the midwife to administer said treatment.

The Arizona rules are also too specific naming which medications can be used with no foresight to the advancement of maternity care.²⁶⁴ The current rules allow midwives to carry Pitocin to stop bleeding, however newer medications have come out that can have the same effect with better results.²⁶⁵ Instead of naming specific medications it would be better for the rules to name classes of medication such as *appropriate hemorrhagics* to account for advancements in maternity care.²⁶⁶

Another concern the rules raise is limiting the postpartum care a midwife can administer. Currently in Arizona, licensed midwives are only allowed to deliver maternity care to women from conception to six weeks postpartum.²⁶⁷ In practice, a midwife is in violation of the rules if she sees a client after she is five weeks and six days postpartum.²⁶⁸ This restriction is wholly unnecessary and limits a midwife's ability to provide well-woman care. A midwife who is qualified to manage the care of a woman and baby through nine months of development and delivery is equally qualified to care for a woman before and after having children. This helps to foster stronger relationships between client and caregiver and saves women from an awkward conversation with their doctor—namely, that for pregnancy—they would rather see a midwife than the doctor that they have seen for years

Lastly, the rules are too restrictive of a woman's right to refuse medical treatment under the Fourteenth Amendment. In respecting a woman's right to refuse medical treatment, every rule regulating midwives should provide

baby for a homebirth. He explained that he would not write a prescription for Vitamin K for a mother planning a home birth because he would not have a patient to write a prescription for until the child is born. *Id.*

263. MATERNAL DECISION MAKING, *supra* note 114, at 3.

264. Interview with Pamela Qualls, *supra* note 104.

265. ARIZ. ADMIN. CODE § R9-16-113(B) (2016).

266. *Compare id.*, with N.M. MIDWIVES ASS'N, PRACTICE GUIDELINES FOR NEW MEXICO MIDWIVES 87 (2008), <http://www.midwiferycollege.org/AcademicProgram/Downloads/ASM/Academics/Syllabi/protocols/NMMA%202008%20practice%20guidelines.pdf> (using "anti-hemorrhagic medications" instead of names of specific medications).

267. ARIZ. ADMIN. CODE § R9-16-101(36) (2016) (defining postpartum as "the six-week period following delivery of a newborn and placenta").

268. Interview with Pamela Qualls, *supra* note 104.

for the woman's right of refusal.²⁶⁹ Midwives already have a standard of care that requires a midwife to follow the wishes of her client but not to continue care for a client who has needs beyond her scope of practice.²⁷⁰ The way the rules are currently written and enforced, a midwife can be penalized for continuing to treat a woman that refuses certain provisions of the rules even if the midwife is qualified to treat the woman.²⁷¹ In fact, there have been a number of cases of the Arizona Department of Health petitioning to suspend the licenses of trained midwives for rule violations that were not out of a midwife's scope of care from a training standpoint.²⁷² In one such case, the Arizona Department of Health petitioned to suspend a midwife's license for one year after she assisted in the birth of healthy twins.²⁷³ The midwife, Diane Gregg, administered care to a woman pregnant with twins whose husband called Gregg on the way to a hospital over an hour away.²⁷⁴ The twins were born without complications and the parents chose not to transfer care to a hospital or doctor when offered by Gregg.²⁷⁵ The Arizona Department of Health Service petitioned to suspend Gregg's license for violating rule R9-16-111(B)(2) which states: "A midwife shall not accept midwifery services or continue midwifery services for a client that has or develops . . . [m]ultiple fetuses."²⁷⁶ On appeal, the court ruled that an emergency situation excepted Gregg from the rules governing her license because the rules do not apply to "[a] person who has no prearranged agreement to provide delivery assistance, but who delivers a baby as a result of an emergency situation."²⁷⁷ The Arizona

269. Compare Interview with Pamela Qualls, *supra* note 104, with PRACTICE GUIDELINES FOR NEW MEXICO MIDWIVES, *supra* note 266, at 87 ("[L]icensed midwives support women's informed choices regarding decisions to test and receive treatments or to decline such testing and treatment.").

270. MIDWIVES ALL. N. AM., STANDARDS AND QUALIFICATIONS, *supra* note 66, at 1.

271. Interview with Pamela Qualls, *supra* note 104.

272. Gregg v. Ariz. Dep't of Health Servs., LC2015-000444-001 DT (Ariz. Super. Ct. Apr. 29, 2016) (Department petitioned for suspension of license because midwife assisted in birth of twins and did not transfer care); Cleckner v. Ariz. Dep't of Health Servs., LC2016-000185-001 DT (Ariz. Super. Ct. Feb. 8, 2017) (Department petitioned for suspension of license and fines because midwife did not transfer care after refusal of testing or complication); Lutrell v. Ariz. Dep't of Health Servs., LC2015-000450-001 DT (Ariz. Super. Ct. Oct. 17, 2016) (Department petitioned for transfer of care because midwife did not perform required testing before twenty-eight-week gestation even though woman was not client of midwife before twenty-eight-week gestation).

273. Gregg, LC2015-000444-001 DT, slip op. at 1.

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.* at 3 (citing ARIZ. REV. STAT. §§ 36-752(A) to (B)(5) (2016)).

Department of Health filed to appeal the superior court's decision but later dropped the case.²⁷⁸

In two other cases of arbitrary rule violations, the Arizona Department of Health petitioned to fine and suspend the license of Wendy Cleckner for failing to discontinue care.²⁷⁹ In the first case, Cleckner failed to discontinue care to her client after the client refused syphilis testing.²⁸⁰ The court found that Cleckner should have informed her client that syphilis testing cannot be refused in the state of Arizona.²⁸¹ This decision of the court violates the Fourteenth Amendment as described above because all medical care should be allowed to be refused by a competent adult.²⁸² The court also stated that Cleckner should have informed her client that due to the rules governing her license, caring for a client who refuses the syphilis test is outside of her scope of care as a midwife as authorized by law.²⁸³ In the second case, Cleckner was determined to fail to discontinue care to a client after a complication arose after birth.²⁸⁴ The complication that arose included a postpartum hemorrhage of more than 500 milliliters.²⁸⁵ Cleckner administered Pitocin to stop the bleeding and called Emergency Medical Services (EMS) as required by the rules.²⁸⁶ The bleeding stopped after the medication was administered and Cleckner informed EMS that the client was fine and refused transfer of care.²⁸⁷ The court ruled that because EMS did not assume direct care of the client, care was not transferred.²⁸⁸ The court stated that Cleckner's client did not know the danger of a postpartum hemorrhage posed and therefore could not refuse transfer of care.²⁸⁹

It is clear from these cases the Arizona Department of Health Service is not looking out for the health and safety of the clients in question because no real or lasting harm was done by not transferring care or refusing medical testing. The clients are not the ones complaining about the care they are

278. *Gregg v. Ariz. Dep't of Health Servs.*, 1 CA-CV 16-0384 (Ariz. Ct. App. Aug. 15, 2016) (order dismissing petition to review).

279. *Cleckner v. Ariz. Dept. of Health Servs.*, LC2016-000185-001 DT (Ariz. Super. Ct. Feb. 8, 2017).

280. *Id.*

281. *Id.*

282. *See Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 288 (1990) (O'Connor, J., concurring) ("Because our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause.").

283. *Id.* at 4.

284. *Cleckner*, LC2016-000185-001 DT.

285. *Id.* at 1.

286. *Id.* at 4.

287. *Id.*

288. *Id.*

289. *Id.*

receiving or seeking suspension of licenses for gross violations of care that put their lives in danger. Rather the Department of Health is attempting to decrease the choices women in the State of Arizona have for prenatal and postpartum care by enforcing restrictive rules on the midwives and individually suspending licenses of midwives who violate rules that have no effect on the care of the client.

VII. CONCLUSION

The wider availability and use of midwifery care in the United States is one way that positive reform can be made to a maternal care system that is failing women. As trained professionals, midwives have the knowledge and skill to assist women through healthy pregnancies and births and offer the hands-on attention that is so helpful in this life stage.

A woman's right to make health care decisions is protected by the Constitution and should be upheld by the states. The evidence shows that women who choose midwifery care are making a safe decision and not endangering their children. In conclusion, Arizona, and all states, should encourage women to seek the maternal care they are most comfortable with by having less restrictive laws on midwifery care.