ELLEN TRACHMAN/ (SBN 238149)
etrachman@trachmanlawcenter.com
1515 Wynkoop Street
Denver, CO 80202
Telephone: 303-243-5014

Attorney for Amici Curaie
The Birth Rights Bar Associations, Improving Birth, Human Rights in Childbirth, the International Center for Traditional Childbearing, California Families for Access to Midwives, California Nurse-Midwives Association, The National Birth Policy Coalition, and the Midwives Alliance of North America

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SAN FRANCISCO

YELENA M. KOLODJI, Petitioner, vs. BOARD OF REGISTERED NURSING; DEPARTMENT OF COMMUNITY AFFAIRS; ROSE GARCIA, Probation Monitor, Department Of Consumer Affairs; REGINA MCLELLAN, BSN, MSHCA, Nurse Education Consultant, Enforcement Division, Department Of Consumer Affairs, Respondents.	Case No. CPF-15-514098

AMICUS BRIEF BY THE BIRTH RIGHTS BAR ASSOCIATION, Improving Birth, Human Rights in Childbirth, the International Center for Traditional Childbearing, California Families for Access to Midwives, California Nurse-Midwives Association, the National Birth Policy Coalition and the Midwives Alliance of North America

IN SUPPORT OF PETITIONER YELENA KOLODJI

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes and Rules

Other Sources

Amici curiae, the Birth Rights Bar Association, Improving Birth, Human Rights in Childbirth, the International Center for Traditional Childbearing, California Families for Access to Midwives, California Nurse-Midwives Association, the National Birth Policy Coalition, and the Midwives Alliance of North America, file this brief as amici curiae in support of the Petitioner in this matter. Amici curiae believe the position advanced by Respondent Board of Registered Nursing poses significant adverse consequences on the continued availability of home birth care in California, even to the extent of effectively ending the ability of nurse-midwives to deliver that care. As such, this case presents a significant issue of consumer access to health care alternatives with repercussions far beyond the impact on Petitioner alone. Amici curiae have read the briefs of the parties as filed and believe they can present additional, substantive argument supporting the position of the Petitioner and pointedly relevant to the well-being of the consuming public.

I. AMICI CURIAE'S RELATIONSHIP WITH THE PARTIES

The amici curiae organizations do not have a formal relationship with the parties.

II. AMICI CURIAE'S INTEREST

Amici curiae's principal interest in this matter is to advocate for the continuing availability of nurse-midwife care in a home birth setting as a safe, regulated, and long-recognized alternative for knowledgeable consumers. The amici curiae are consumer organizations concerned with maintaining access to a full range of maternity care options. They believe that nurse-midwives are an indispensable part of an optimally functioning maternity care system. These organizations include California Families for Access to Midwives and nationally active organizations that represent families, including Improving Birth. They are concerned that the impact of this case will be to limit access to midwives like Petitioner though the unwarranted and unduly burdensome application of nursing regulations.

The amici curiae include the California Nurse-Midwives Association, a professional association for nurse-midwives like the Petitioner, and the Midwives Alliance of North American, a professional association for midwives of all credentials. Also included among the amici curiae are advocacy organizations that address broader maternity care issues such as

quality of care, rights in birth, licensure, credentialing, access, and equity. These include the Birth Rights Bar Association, Human Rights in Childbirth, The National Birth Policy Coalition, and the International Center for Traditional Childbearing. These organizations are interested because they recognize the essential role of nurse-midwives in the health care system and seek to ensure that the health care system is equitable.

Together these amici curiae offer the Court a substantive understanding of the questions it faces in deciding Ms. Kolodji's case. They will help the Court put this decision in context with regard to how the Board of Registered Nursing's position would impact nursing professionals, the health care system, and California families.

III. AMICI CURIAE'S STATEMENT OF POSITION

Amici curiae's position is that in the proper context of history and the law the Board of Registered Nursing seeks to constrain and potentially eliminate Petitioner's homebirth midwifery practice by imposing, in an almost punitive fashion, licensing requirements that are far in excess of those required by law or customary in the profession. Amici curiae's position is that the California Legislature gave the Board of Registered Nursing authority to regulate midwives like Ms. Kolodji, but not the authority to eliminate home birth midwifery through the creation of rules and regulations that no midwife can reasonably follow. Amici curiae's position is that the Court should promote access to midwives as a matter of good healthcare policy, ethics, and human rights by finding for the Petitioner.

IV. ARGUMENT

A. Background

i. *Origins and History of Midwifery*

Midwives provided care and support to the majority of pregnant women in the United States for nearly 250 years. *See* Judith Pence Rooks, Midwifery & Childbirth in America 17-18 (1997) [hereinafter Rooks]. Like the midwives of the Middle Ages who learned their trade by providing care to pregnant women, early Modern Era midwives in North America gained

experience by sharing skills and attending births alongside more experienced midwives. Sheila Kitzinger, Rediscovering Birth 134 (2000) [hereinafter Kitzinger].

At the beginning of the 20th century, midwives provided care for the majority of pregnant, laboring, and postpartum women in the United States. *See* Robbie Davis-Floyd & Christine Barbara Johnson, Mainstreaming Midwives: The Politics of Change 32-44 (2006) [hereinafter Davis-Floyd]. In 1923, an estimated 60,000 midwives practiced in the United States – a figure that researchers estimate to be nearly double the number of obstetricians in the United States today. Jennifer Block, Pushed: The Painful Truth About Childbirth and Modern Maternity Care 213 (2007).

As physicians gained prominence and political power in the 19th and 20th centuries, they encouraged local governments to create laws banning the practice of midwifery. Davis-Floyd, *supra*, at 32. As a result, midwives faced difficulties in legally practicing their trade because licensing laws served to legitimize only university-trained physicians. Barbara Ehrenreich & Deidre English, Witches, Midwives, and Nurses: A History of Women Healers 53 (2d ed., 2010) [hereinafter Ehrenreich]. Additionally, the majority of 19th century midwives were recent European immigrants and African-American women, and efforts to discredit their skills were rooted in racism. Kitzinger, *supra*, at 136. In an effort to discourage women from seeking the services of midwives, physicians and obstetricians engaged in effective smear tactics, referring to midwives as unskilled, unhygienic, and incapable care providers. Ehrenreich, *supra*, at 85.

ii. *Development and Enactment of Medical Practice Laws*

Efforts by organized medicine to discredit and suppress its midwife competition went beyond the above-described disinformation campaign. Beginning in the 19th century, allopathic physicians lobbied state legislatures for all-encompassing "medical practice" laws, some of which incorporated maternity care within the definition of "medicine." Rooks describes this campaign and the laws that resulted:

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

By a remarkable bit of legislative sleight of hand, these laws expanded the scope of care that doctors could legally provide while, simultaneously classifying the partially-overlapping scopes of practice of midwives and other as-yet unlicensed practitioners as the unauthorized practice of medicine. *See, generally,* Davis-Floyd, *supra*, at 32-33; *see also,* Ehrenreich, *supra*, at 85-86.

As physicians gained prominence in the 19th and 20th centuries, they lobbied state governments to enact licensure laws that created broad and preemptive scopes of practice, written in language intended to encompass the entire range of health care services. Barbara Safriet, who has written extensively on scope of practice regulatory issues, describes the process:

> Across the country, physicians (also known as medical doctors or "MDs") were the first health care providers to secure licensure. By the early 1900s, so-called "medical practice acts" had been adopted in each state, and being first on the scene, physicians, perhaps understandably, swept the entire human condition within their purview. In almost every state, their legislatively-recognized scope of practice gave them exclusive domain over "the practice of medicine." Barbara Safriet, *Closing the Gap Between Can and May in Health Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 Yale J. on Reg. 301, 306 (2002) [hereinafter Safriet, *Closing the Gap*] [citing, generally Paul Starr, *The Social Transformation of American Medicine*, 102-12 (1982) (hereinafter Starr) ("an excellent description of the evolution of organized medicine's licensure activities")].

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

> propelled solely by the advance of science and the satisfaction of human needs. The history of medicine has been written as an epic of progress, but it is also a tale of social and economic conflict over the emergence of new hierarchies of

> power and authority, new markets, and new conditions of belief and experience. Starr, *supra*, at 4.

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

With such laws the cornerstone of health professional licensing, other health care providers, in turn, found themselves obliged to secure legislative recognition and authorization to provide their own scopes of practice, *which would nearly always necessarily overlap with some aspect of medicine's overly-broad scope*. But in the early twentieth century, American midwives were not only unprepared to take on organized medicine, but were also socially, politically, and economically unable to fight back. Rooks points out that in the early twentieth century, "[t]here was no parallel effort to license and improve the education of midwives" who

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

such as state legislatures and public health departments. Rooks, *supra*, at 21, 24.

Whether immigrants serving urban ethnic enclaves and African-American women serving the rural south, such groups were singularly unempowered to win legislative battles against groups of educated white men, who added claims of scientific superiority to their existing political, socioeconomic, and cultural advantages. The initial result, according to Ehrenreich and English, was widespread medical monopoly underwritten by the state legislatures. Ehrenreich,

supra, at 85. "In state after state, new tough physician licensing laws sealed the doctor's monopoly on medical practice. All that was left was to drive out the last holdouts of the old people's medicine – the midwives." *Id.* Once this sweeping authority was in place, organized medicine and state public health departments turned their attention to eradicating midwives – or, at least, controlling and minimizing the role they played.

B. Midwifery is Not the Practice of Medicine.

Midwifery and medicine are fundamentally different professions *because of critical differences in the underlying models of care,* developed separately from each other throughout history. These differences are found in the philosophical underpinnings, the creation of the two professions, and in the actual provision of care. These important distinctions have been noted and described by numerous scholars and researchers for decades. *See, e.g.*, Barbara Katz Rothman, *Two Models of Maternity Care: Defining and Negotiating Reality* (1979) [hereinafter Rothman]. In addition, ample statutory support exists for the contention that midwifery is not the practice of medicine.

i. *Midwifery and Medicine are Two Distinct Models of Care.*

In 1979, sociologist Barbara Katz Rothman described the significant differences between the midwifery model of care and the medical model practiced by most physicians. *See* Rothman, *supra.* Rothman's analysis is summarized in the following chart:

Midwifery Model of Care	**Medical Model of Care**
Focus on health, wellness, prevention	Focus on managing problems and complications
Labor and birth as normal physiological processes	Labor/birth as dependent on technology
Lower rates of interventions	Higher rates of using interventions
Mother gives birth	Doctor delivers baby
Care is individualized	Care is routinized

Childbirth Connection, *Choosing a Caregiver*, http://www.childbirthconnection.org/article.asp?ck=10163#model.

American medical anthropologist Robbie Davis-Floyd later expanded upon Rothman's work and noted that the current U.S. medical model is "founded in science, effected by technology, and carried out through large institutions governed by patriarchal ideologies in a profit-driven economic context." Robbie Davis-Floyd, *The Technocratic, Humanistic, and Holistic Paradigms of Childbirth*, 75 Int'l J. Gynecology & Obstetrics S5-S23 (2001). She contrasted this with the humanistic model which seeks to make healthcare "... relational, partnership-oriented, individually responsive, and compassionate." *Id.* at s10.

More recently, researchers with the Cochrane Collaboration identified and compared what they called the "midwife-led model of care" with other models of care, including obstetrician-provided care, family doctor-provided care, and shared models of care. *See* Marie Hatem, *Midwife-led versus other models of care for childbearing women*, The Cochrane Collaboration (2009), http://apps.who.int/rhl/reviews/CD004667.pdf. The authors distinguished the midwife-led model and described it as follows:

> The midwife-led model of care is based on the premise that pregnancy and birth are normal life events and is woman-centred. The midwife-led model of care includes: continuity of care; monitoring the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle; providing the woman with individualised education, counselling and antenatal care; continuous attendance during labour, birth and the immediate postpartum period; ongoing support during the postnatal period; minimising technological interventions; and identifying and referring women who require obstetric or other specialist attention. *Id.* at 3.

In modern maternity care systems around the world, midwives as distinct from physicians, are the primary caregivers for normal, healthy women at all stages of their reproductive lives, including pregnancy and childbirth. *Id.* at 2. The American childbirth setting, however, has inserted a *primary* caregiver whose specialty is surgery and pathology

(obstetrician), where someone whose specialty is normal childbirth (midwife) should be; although their fields overlap, they are clearly distinct. Physicians might, in fact, benefit from studying midwifery, as is the case in the Netherlands, where physicians who wish to provide care for normal births are required to study midwifery formally for one year. Ted (G. J.) Kloosterman, *Why Midwifery?*, The Practising Midwife, Spring 1985, at 10.

ii. *Legal Precedent Establishes Midwifery as a Distinct Profession.*

Building on these practical distinctions between midwifery and medicine, we look now to the definitions in law. Every state's medical practice act features a provision proscribing activities that the medical profession considers its own. While wording varies slightly from state to state, most medical practice acts contain references to treating, diagnosing, or prescribing for any disease, injury, pain, or deformity. *See, e.g.*, Tex. Occ. Code § 151 (1999). Some medical practice acts include the word "condition" in that list. *See, e.g.*, Fla. Stat. Ann. § 458.305 (2011). Some even include "pregnancy." *See, e.g.*, 26 Vt. Stat. Ann. § 1311 (2011).

Medical practice acts generally forbid anyone from engaging in these activities unless: i) authorized through licensure as a physician, ii) authorized through recognition as another type of health practitioner, or iii) otherwise exempted from that state's medical practice act (such as federal employees who are physicians, or "Good Samaritans" who give aid in an emergency). *See, e.g.*, Utah Code Ann. § 58-1-307 (2012). *When a state licenses or explicitly permits the practice of a health care profession separate from medicine (iii above), engagement in that newly recognized profession no longer constitutes the practice of medicine.* The state has effectively "carved out" the other profession from the definition of medicine and created a parallel regulatory scheme.

In the majority of such cases, the courts have found that midwifery is *not* the practice of medicine. *See, e.g.*, *Albini v. Conn. Med. Examining Bd.*, 72 A.3d 1208 (Conn. App. Ct. 2013); *Banti v. State*, 289 S.W.2d 244 (Tex. Cr. App. 1956); *Carr v. Dep't of Health*, District of

Columbia Office of Administrative Hearings, C.A. No. 2011-DOH-00002 (May 22, 2013); *Peckman v. Thompson*, 745 F. Supp. 1388 (C.D. Ill. 1990); *State Bd. of Nursing v. Ruebke*, 913 P.2d 142 (Kan. 1996); *State v. Mountjoy*, 891 P.2d 376 (Kan. 1995).

In cases where courts *have* held midwifery to fall within the definition of medicine, the medical practice act in question included treatment of a "condition" or otherwise explicitly included pregnancy and birth. *See, e.g., Bowland v. Mun. Ct. for Santa Cruz*, 134 Cal. Rptr. 630 (Cal. Sup. Ct. 1976); *Smith v. State*, 459 N.E.2d 401 (Ind. App. 1984); *State ex rel. Mo. State Bd. of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219 (Mo. 1986).

Even when separate professions are identified and permitted, scopes of practice overlap. Consider, for example, the overlapping practice areas of psychiatrists and social workers (mental health), ophthalmologists and optometrists (eye care), and physiatrists and physical therapists (physical rehabilitation). The same applies to obstetrics and midwifery: while the subject matter of midwifery and medicine overlap (care of women in pregnancy and childbirth), the distinction between the professions remains.

A recent Connecticut case, for example, held that an obstetrician's testimony in the case of a midwife did not meet not meet the statutory requirement of a "similar health care provider," notwithstanding the OB's familiarity with the subject matter and relevant standard of care. *Wilkins v. Conn. Childbirth & Women's Ctr.*, 42 A.3d 521, 523 (Conn. App. 2012); *see also Sermchief v. Gonzales*, 660 S.W.2d 683 (Mo. 1983) (addressing professional overlap within the context of advanced practice nurses ("APRNs")).

C. The Relationships Between Midwives and Physicians

i. *States, including California, Recognize and Regulate Midwives as Independent Practitioners.*

In nearly all states, including California, the laws governing the licensure and practice of nurse midwives recognize CNMs as licensed independent practitioners who are fully accountable

as professionals for the outcomes of care they provide. The Joint Commission (formerly The Joint Commission on Accreditation of Healthcare Organizations), the Hospital Accrediting Organization, notes that licensed independent practitioners are not directed or supervised by other healthcare providers, but rather oversee the "delivery of care" that they provide. The Joint Commission, *Accreditation Manual for Hospitals* (2007) Am.Apx 065.

Most state statutes and regulations governing midwives do not require physicians to supervise, direct, or otherwise control midwives. Currently, midwives meet the definition of Licensed Independent Practitioners in all but five states. As such, midwives may legally provide patient care services within the scope of practice. This includes admitting patients to hospital, without physician supervision, direction, or control. *See* Lisa Summers, *Credentialing Certified Nurse-Midwives and Certified Midwives*, Synergy (2003), Am.Apx 088.

ii. *Recent Trends Emphasize Professional Autonomy for Midwives.*

Although state laws vary, states increasingly enact practice laws that adopt or reference the American College of Nurse Midwives' (ACNM) standards and emphasize professional autonomy and Certified Nurse Midwife (CNM) accountability. Under the standards, the hallmark of midwifery is the independent management of client care within an interdependent healthcare system where professionals and institutions interact. For instance, Alaska regards CNMs as "advanced nurse practitioners" and authorizes them to "perform acts of medical diagnosis and prescription and dispensing of medical, therapeutic, and corrective measures." Alaska Stat. § 08.68.410, Add. 052. Alaska practice regulations adopt the ACNM standards and clearly delineate a midwife's responsibility to include deciding if consultation or referral to another provider is required. Alaska Admin. Code tit. 12, 44.400 et seq., Add. 054-055. Similarly, the practice law in Maine provides that CNMs are "independently responsible and accountable" for providing healthcare services for women, including primary care for women and infants,

gynecology, and case management during pregnancy and childbirth. *See* Me. Rev. Stat. Ann., tit. 32, 2101 et seq.; Me. Code R. 02-380, Ch. 8. Add. 106-07.

Additionally, the state of Washington regulatory board adopted ACNM's standards and provided by rule that CNMs, as advanced registered nurse practitioners, are "qualified to assume primary responsibility and accountability for the care of their patients" and "shall be held individually accountable for the practice based on... the scope of his/her education, demonstrated competence and advanced nursing expertise." Wash. Admin. Code § 246-840-300, Add. 144-45.

These laws and rules have several common themes, including reference to or adoption of the national standards; strong emphasis on the individual responsibility and accountability of the midwife for the healthcare provided and its outcome; and the continuation of that responsibility even when consultation takes place. The laws also unambiguously recognize that the midwife is the one who determines whether consultation or referral is needed. This determination is based upon the midwife's assessment of the client's health status and whether it may require services outside of the midwife's scope of practice. A midwife who determines her client needs such services remains accountable for her decision to consult or refer. Accountability is not necessarily transferred to the consultant. Rather, the consultant assumes no responsibility for the patient unless and until the midwife makes the referral, and the referral is accepted or a plan for collaborative care is instituted.

iii. *Appropriate Level of Responsibility for a Given Situation under American College of Nurse Midwives and the American Congress of Obstetricians and Gynecologists.*

There is a common understanding shared between ACNM and ACOG regarding the professional interactions that occur between their members, ranging from informal consultation through collaborative management to referral. ACNM and ACOG have developed a joint statement of practice relationships, which sets forth the mutual understanding and commitment of the two organizations regarding "communication and collegial relationships" between their

members. American College of Obstetricians and Gynecologists, *Joint Statement of Practice Relationships between Obstetrician Gynecologists and Certified Nurse-Midwives/Certified Midwives* (2003), Am. Apx. 092.

In addition to the joint statement, each organization recognizes a spectrum of interactions between OB/GYN physicians and midwives. At one end of the spectrum, ACNM uses the term "informal consultation" to designate a consultation that does not give rise to a consultant-client relationship. The Standards define the consultation as "the process whereby the CNM . . . who maintains primary responsibility for a woman's care seeks the advice or opinion of a physician or another member of the healthcare team." Am. Apx. 088. ACOG recognizes the same process in slightly different terms, referring to "informal consultation" as "professional dialogue." American College of Obstetricians and Gynecologists Committee on Ethics, *Committee Opinion No. 365: Seeking and Giving Consultation* (2007). ACOG describes three levels of consultation in addition to the more informal professional dialogue. By ACOG's definitions, consultation is "the act of seeking assistance from other physician's or healthcare professional's for diagnostic studies, therapeutic interventions, or other services that may benefit the patient." *Id.* at 2. "Professional dialogue", on the other hand, is a process whereby "clinicians share their opinions and knowledge with the aim of improving their ability to provide the best care to their patients. Such dialogue...may arise in response to the needs of a particular patient." *Id.* at 1.

D. California Developments and Cases Regarding Regulation of Midwives

i. The Osborn Case

The 1999 Osborn case involved the Medical Board of California (Complainant) and a licensed Midwife Alison Osborn (Respondent). *In re* Osborn, No. 1M-98-83794, (Dep't Consumer Affairs 1999). Complainant alleged that Respondent violated the Licensed Midwifery Practice Act of 1993 (hereafter referred as *The Act*) by "practicing midwifery without physician supervision" and prayed for revocation and/or suspension of the respondent's license. *Id.*

The court in the Osborn case held that "in the interest to promote efficacy of the Act, a licensed midwife who possessed a relationship with a California Physician and Surgeon has feasibly and reasonably satisfied the ambit of the Act." *Id.* Accordingly, the court found no cause to revoke or suspend Respondent's license pursuant to the Cal. Bus. & Prof. Code § 2519(e), in conjunction with §§ 2507(a) and (b), for unprofessional conduct arising from lack of "supervision."

"Supervision," as defined by California laws and regulations, does not require the physical presence of the supervising physician. Cal. Bus. & Prof. Code § 2507(c). Physicians are also not required to oversee activity or accept responsibility for services rendered by licensed midwives. Cal. Bus. & Prof. Code § 3501(f). This differs from how physicians supervise licensed physician's assistants. *Id.* The reality in California is such that no surgeon or physician supervises licensed midwives attending homebirths due to their own liability concerns or restrictions enacted by malpractice and/or liability insurers.

Despite these challenges in California, licensed midwives collaborate with physicians in an effort to practice their trade and continuously improve their knowledge and skills. Through these cooperations between midwives and sympathetic physicians, they expand the options available to patients while simultaneously developing professional relationships for collegial referral and assistance, collaboration, and emergency aid. These collaborative, yet informal, partnerships are formed without direct or accountable physician or surgeon supervision of licensed midwives.

ii. *Requiring a Supervisory Relationship will Impede Access to Care.*

Although midwives care for women of all socioeconomic backgrounds, nearly 70% of women attended by midwives are considered vulnerable by virtue of their age, education, socioeconomic status, ethnicity, and/or location of residence. According to Jeanne Raisler, more than one-third of CNM clients reside in areas where a higher-than-average number of people are

living below the poverty level. Jeanne Raisler, *Midwifery Care of Poor and Vulnerable Women, 1925-2003*, 50 J. Midwifery & Women's Health 120 (2003), Am. Apx. 043.

Historically, nurse-midwives worked in resource-poor communities who reported high infant and maternal mortality rates, such as Native American reservations, rural southern health departments, and inner-city hospitals. *Id.* at 113. Midwives worked with clients who experienced poorer health and inadequate health care, including low-income women, immigrant women, women of color, and women otherwise unable to access to care. *Id.* Most early midwives felt it their calling to serve marginalized women and their families, *id.*, and many present day midwives follow in their footsteps.

Requiring supervisory relationships between midwives and physicians will restrict the autonomy of midwives over their practices. Consulting physicians should rightfully be paid for their time and expertise in providing consultations. However, this may render midwifery services too costly, thereby thwarting the efforts of midwives to increase access to comprehensive, accessible prenatal care for lower-income women and families. Thus, the effect would deprive vulnerable women and their families access to the care they need but cannot otherwise access.

In addition, California's patient pool is likely to expand as a result of the state's Medicaid expansion under the Affordable Care Act. As supply dwindles, the demand for trained, skilled attendants for out-of-hospital birth has increased dramatically on a national level over the last ten years. Marian F. MacDorman et al., *Trends in Out-of-Hospital Births in the United States, 1990-2012*, 144 Nat'l Ctr. Health Stat. Data Brief (March 2014). Therefore, requiring supervisory relationships will limit midwives' professional autonomy and independent decision-making, thereby thwarting efforts to meet the increasing needs for midwives.

E. California Should Promote Access to Midwives as a Matter of Good Healthcare Policy, Ethics, and Human Rights.

Midwifery-led care - both in and out of hospitals - is universally acknowledged as resulting in fewer complications and overall better maternal and infant health outcomes. *See, e.g.*, Jane Sandall et al., *Midwife-led continuity models versus other models of care for childbearing women*, The Cochrane Collaboration (Aug. 21, 2013). In 2014, the World Health Organization (WHO), recognizing midwives as the appropriate primary caregivers for pregnant women around the world, *see* Hatem, *supra*, issued a call to action urging countries to, among other things, "Champion midwifery and ensure all women have access to these services," "Provide first-level midwifery close to the woman and her family, with seamless transfer to next-level care when needed," "Support regulation and legislation for midwifery practice," and "Develop and implement midwifery licensing, with continued education and renewal requirements." World Health Org., *Fact Sheet: The State of the World's Midwifery 2014* 2-3 (2014).

i. *Treating Home Birth as a Legitimate Healthcare Choice Supports Public Health, Driving it Underground Endangers Public Health.*

In line with WHO recommendations, the U.K.'s National Institute for Health and Care Excellence (NICE) recently released national guidelines advising that 45% of women (healthy and at low risk for complications) would be *safer* in midwife-led, out-of-hospital birth settings, with no additional risk to their babies. Katrin Bennhold & Catherine Saint Louis, *British Regulator Urges Home Births Over Hospitals for Uncomplicated Pregnancies*, N.Y. Times, Dec. 3, 2014.

The U.S., meanwhile, lags well behind much of the developed world in outcomes and policy. Fifteen years ago, researchers relying on WHO data identified *29 nations with lower estimated maternal mortality rates*, *35 with lower early neonatal mortality rates*, and *33 with lower neonatal mortality rates* than the United States. Kenneth Hill et al., *Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data*, 370 Lancet 1311

(2007). Ten years ago women were less likely to die of maternal mortality in 33 other countries. *Id.* Four years ago, Amnesty International called American maternity care a "crisis." This year, a study published in the medical journal The Lancet revealed the U.S. is one of only eight countries in the world with a rising maternal mortality rate over the last ten years. Carol Morello, *Maternal deaths in childbirth rise in the U.S.*, Wash. Post, May 2, 2014. It is also the most expensive at over $50 billion annually. Feeding into that cost is the fact that surgical specialists (obstetricians), rather than cost-effective midwives, attend over 90% of all births. Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. Times, June. 30, 2013. Notably, the U.S. deviates from international practice around midwifery, with some states going so far as to criminalize midwives. *See* Block, *supra*, at 213 ("The United States is the only country to have made the modern home-birth midwife an outlaw.")

ii. *The State Should Not Constrain the Human Right to Decide How, Where, and With Whom One Gives Birth.*

Beyond the cost effectiveness and good policy of robust access to midwifery care in all settings, the *right* to choose midwifery care has been recognized by the European Court of Human Rights--specifically in regard to a woman (Anna Ternovszky) who alleged that she could not safely exercise her right to choose the circumstances of childbirth, when the legal right to home birth was unclear and her midwife could face legal sanction for attending her. *Ternovszky v. Hungary*, No. 67545/09, at 2, 6 (Eur. Ct. H.R. Dec. 14, 2010). In *Ternovszky*, the court found that women have the human right to determine where, how, and with whom they give birth. *Id.* at 7-8. The role of the state, then, is to support them in exercising that fundamental right--not to treat the choice of home birth as illegitimate and drive it underground.

Midwives are forced underground when the state regulatory scheme fails to recognize midwifery as distinct from medicine, fails to enact the will of the legislature, fails to recognize their autonomy over the practice by requiring supervision, and makes it impossible for qualified

midwives to obtain a permit. When this happens, the families of California suffer. They face a lack of legitimate health care options that is unparalleled in the world, and should be unheard of in a country as well-resourced as the United States.

Paul Burcher, M.D., Ph. D., is an Oregon physician whose obstetric practice "embrace[s] a model of informal collaboration" with their midwife colleagues. He asserts that, based on his experience, the experiences of his physician colleagues, and the example of the Netherlands model, the safety of homebirth is maximized by treating it as "a reasonable option that some women will choose." Paul Burcher, *What's an Ethical Response to Home Birth?*, ObGyn.net (Dec. 4, 2014). The ethical professional responsibility of physicians, he says, "must include supporting all of the birth options women have and to make each as safe as possible. *Id.* We argue the same is true for the state.

V. CONCLUSION

For the foregoing reasons, we assert that it is particularly important to manifest fair and even-handed regulatory systems. We also affirm the due process rights of women and urge this Court to protect the fundamental rights of women to choose the circumstances in which they give birth. In the present case, we ask the Court to affirm the independent role of midwifery in California's health care system and find for Ms. Kolodji.

Respectfully submitted,

Dated: May 21, 2015

Ellen Trachman
Counsel of Record

Deborah Fisch
Susan Jenkins
Indra Lusero
Shandanette Molnar

Priya Morganstern

Birth Rights Bar Association
3218 Vallejo Street
Denver, CO 80211

Attorneys for Amici Curiae