SEEKING REPRODUCTIVE JUSTICE: WRITTEN PRACTICE AGREEMENTS AND [THE LACK OF] HOME BIRTH CHOICE

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INTRODUCTION

Sabrina was seven months pregnant with her first child when St. Vincent's Hospital in New York City closed its doors at the end of April, 2010. Little did she know, even though she was planning a home birth with a licensed midwife, the hospital closure meant she would be forced to change her birthing plans. In New York, up until the end of July, 2010, as in most states in the United States, a licensed midwife was required to have a written practice agreement with an obstetrician or a hospital if she was going to practice outside of a hospital setting. St. Vincent's was the only hospital that "backed" home birth midwives in New York. As such, Sabrina's midwife, along with six of the other thirteen home birth midwives in New York, was no longer legally able to practice. With two months to her due date, decisions needed to be made: should Sabrina continue with her birth plans, risking that her midwife might get "caught" practicing without the necessary written practice agreement? Should she acquiesce and have a hospital birth despite her desire to give birth at home? Or, should she risk birthing at home without a midwife? None of these options are particularly desirable. And, they all result in reproductive oppression.[1]

The purpose of this paper is to explore the reproductive justice impact of the regulatory requirement that certified nurse-midwives (CNMs) have written practice agreements (WPAs) with obstetricians or hospitals in order to practice home birth. I begin this paper with some background – an overview of the state legislation relating to WPAs, a brief look at home birth in America, and a general introduction to Reproductive Justice Theory. In the model of Reproductive Justice, I will then look at the interests of the parties who are key to this issue: the state, midwives, parents, physicians and hospitals, and the pharmaceutical industry. Following this, I will review the case law that relates to a parent's right to choose where and how to birth. I will then turn to how the legislation creates reproductive oppression. Finally, this paper will examine two options for working toward reproductive justice in this area: attacking legislation on legal grounds and working for legislative change.

I. BACKGROUND

A. Overview of state legislation

A written practice agreement (WPA), also referred to as a signed collaborative agreement, is a signed document that outlines a physician-midwife relationship for care of a midwifery client. Depending on the state, these agreements can involve language that creates a supervisory relationship or a collaborative relationship.[2] Currently, only the District of Columbia and seventeen states do *not* have WPAs: Alaska, Arizona, Connecticut, Idaho, Iowa, Maryland,

[1] This story is a hypothetical one based loosely on the facts about St. Vincent's closing expressed in: Anemona Hartocollis, *St. Vincent's Closing Puts Midwives in Jeopardy*, N.Y. TIMES, May 5, 2010, *available at* http://www.nytimes.com/2010/05/06/nyregion/06midwives.html?_r=1.
[2] Alyson Reed & Joyce E. Roberts, *State Regulation of Midwives: Issues and Options*, 45 J. MIDWIFERY & WOMEN'S HEALTH 129, 140 (2000) (12 states and 28 states, respectively).

Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, Washington, and Wyoming.[3] Proponents argue that these agreements ensure patient safety and manage liability;[4] while opponents claim that WPAs create confusion about the physician's role, unfair economic disadvantages to midwives, and instability for the midwife and her clients, as they can be revoked.[5]

B. Overview of home birth in America

Although today home birth makes up only about 1% of births in the Unites States, prior to the mid-1900s, most babies were born at home.[6] The majority of these babies were "caught" by midwives or other community members;[7] while today – and since the late 1960s – 99% of babies are born in a hospital.[8] As the specialty of obstetrics grew in the early part of the twentieth century, so did the perception that a hospital is the safest place to give birth.[9] Quickly, home birth became associated with antiquated and less safe means of birthing, falling out of mainstream culture.[10]

Despite the majority trend, according to 2005 statistics, around 24,000 people plan home births every year – mostly attended by a midwife (although usually a lay or direct-entry midwife).[11] CNMs delivered roughly 8% of all babies born in 2005 – 93% of these births were in a hospital – and about 1.3% (or 4,500) were home births. [12] CNMs are legally allowed to work in every state, but heavy regulation of the profession keeps almost all of them under physician supervision in institutional settings.[13]

So, what is the attraction of home birth for this small number of parents? In their study about why women choose to plan a home birth, Boucher et al. explain that the five most common reasons are safety, avoidance of medical interventions, a negative previous hospital experience, control over the process, and a comfortable environment. [14] Ironically, it is the question of safety and the reduced ease of medical intervention that is most often cited by opponents of home

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[3] New York State Association of Licensed Midwives (NYSALM), *What Does the Midwifery Modernization Act Mean for You?*, NYSALM ONLINE, http://www.nysalm.org/MMA%20fact%20sheet.pdf (last visited Nov. 15, 2010); *see also* American College of Nurse-Midwives (ACNM), *State Legislative and Regulatory Developments*, ACNM ONLINE, http://www.midwife.org/state_legislation.cfm (last visited Nov. 15, 2010).

[4] The American Congress of Obstetricians and Gynecologists (ACOG), *Memorandum in Opposition*, ACOG ONLINE, http://www.acog.org/acog_districts/dist_notice.cfm?recno=1&bulletin=3342 (last visited Nov. 15, 2010).

[5] *See* American College of Nurse-Midwives (ACNM), *Position Paper: Requirements for Signed Collaborative Agreements Between Physicians and Certified Nurse-Midwives (CNMs) or Certified Midwives (CMs)*, ACNM ONLINE, http://www.midwife.org/siteFiles/position/Requirements_for_Signed_Collaborative_Agreements_4.06.pdf (last visited Nov. 15, 2010); NYSALM, *supra* note **Error! Bookmark not defined.**.

[6] Debora Boucher et al., *Staying Home to Give Birth-Why Women in the United States Choose Home Birth*, 52 J. MIDWIFERY & WOMEN'S HEALTH 119, 119 (2009).

[7] Stacy Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 63 (2004).

[8] Boucher et al., *supra* note 6.

[9] Joleen Susan Pettee, *Midwifery: Do Parents Have a Constitutional Right to Choose the Site, Process, and Attendant for the Birth of their Baby?*, 24 J. CONTEMP. L. 377, 379-81 (1998).

[10] *Id*.

[11] Joyce A. Martin et al., *Births: Final Data for 2005*, 56 NAT'L VITAL STAT. REP. 1, 70 (2007).

[12] *Id.*

[13] Tovino, *supra* note 7, at 69.

[14] Boucher et al., *supra* note 6, at 122-24.

birth.[15] Whatever the reasons that people believe home birth is desirable or not – safe or not – what is clear is that, although it makes up only a small minority of births in the United States, home birth is a real option for some parents.

C. Overview of Reproductive Justice Theory

Born in the 1990s, Reproductive Justice is a framework for looking at the intersection of all factors affecting a person's ability to determine her or his own reproductive identity and future.[16] It focuses equally on the right to have a child, the right to not have a child, and the right to parent in the way one chooses (including how to birth).[17] The framework also looks at the factors that facilitate these rights, like a living wage, accessible education, and public services.[18] It uses the term "reproductive oppression," meaning "the control and exploitation of women, girls, and individuals through our bodies, sexuality, labor, and reproduction," to identify the systemic barriers to these rights.[19] It recognizes three contexts for fighting reproductive oppression: reproductive health (focusing on service delivery), reproductive rights (centering on legal issues), and reproductive justice (dealing with growing the movement).[20] This paper deals with the reproductive rights component of the framework, specifically in relation to the right to parent.

II. BALANCING THE INTERESTS

The state has an obvious and legitimate interest in the health and safety of the general public, and this is primarily what governs its interest in WPA legislation. In fact, in order to justify the strict regulation of CNMs, courts have relied on the rationale that, if the statute is substantially related to public health and welfare, it must stand.[21] As was mentioned above, safety (both of home birth and hospital birth) is the major concern of parties on both sides. And, as to be expected, there are studies and other evidence that support both opponents and proponents of midwife-assisted home birth. [22] Because there is no completely conclusive evidence on the safety of home birth, it is up to the state to determine what regulation is appropriate and is in the interest of public safety and welfare.

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[15] *See* The American Congress of Obstetricians and Gynecologists (ACOG), *ACOG Statement on Home Births*, ACOG ONLINE (Feb. 6, 2008), http://www.acog.org/from_home/publications/press_releases/nr02-06-08-2.cfm.
[16] *See* Loretta Ross, *What is Reproductive Justice?*, REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE AND SOCIAL CHANGE, 4, 4-5; Loretta Ross, UNDERSTANDING REPRODUCTIVE JUSTICE (May 2006), http://www.sistersong.net/publications_and_articles/Understanding_RJ.pdf.
[17] *Id.*
[18] *Id.*
[19] Ross, *Understanding Reproductive Justice*, *supra* note 166, at 2.
[20] *See* Ross, *What is Reproductive Justice?, supra* note 16; Ross, UNDERSTANDING REPRODUCTIVE JUSTICE, *supra* note 16.
[21] Leigh v. Bd. of Registration in Nursing, 506 N.E.2d 91, 94 (1987).
[22] *See, e.g.,* Patricia A. Janssen, *Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician*, 181 CAN. MED. ASSOC. J. 353; Kenneth C. Johnson & Betty-Anne Davis, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America*, 330 BMJ 1416 (2005); Joseph R. Wax et al., *Maternal and Newborn Outcomes in Planned Home vs. Planned Hospital Births: A Metaanalysis*, 203 AM. J. OF OBSTETRICS & GYNECOLOGY (2010).

Naturally, CNMs have a vested interest in the legislation that regulates their profession, especially surrounding WPAs. Although they do not necessarily advocate for less regulation of midwifery, CNMs do assert that women and newborn health is enhanced when a midwife can practice independently within the "scope of practice while fostering consultation, collaborative management, or seamless referral and transfer of care when indicated."[23] But, they also express that WPAs imply that a midwife needs physician supervision and that they can create economic disadvantages for midwives.[24]

Choosing where and how to birth one's child is one of the most personal and intimate choices a parent can make. The right to choose a preferred birthing option, as will be discussed in much more detail in the next section of this paper, is a parental right that should be protected. Every parent has an interest in the well-being of her or his developing child – whether in the womb, in the process of entering the world, or after birth. Case law establishes rights to parents in the first and last of these stages,[25] but remains unclear on the middle one – when a parent can choose a birthing option. As Cohen points out, choosing where and how to birth can "express deeply held beliefs about nature and religion, and [these] are often the product of parental, political, religious, and feminist choices."[26] The nature of this deeply personal and important decision makes the parental interest in legislation that could limit birthing options a very legitimate one.

The case for physician and hospital interest in legislation that requires WPAs can easily be made. First, WPAs ensure appropriate allocation of liability – midwives will be able to obtain liability insurance, as they will remain lower-risk with a WPA, keeping liability concerns at bay.[27] However, the argument that WPAs increase a physician's liability has also been made.[28] Secondly, there is little doubt that eliminating WPAs has the potential to increase the number of midwife-operated birthing options (both birthing centers and home birth practices). With the cost of a home birth at significantly less than that of a hospital birth,[29] as well as a dramatic increase in chance of fewer interventions,[30] and the possibility of better birth outcomes,[31] it is easy to see how a physician may feel threatened by more midwives being able to take on clients. As such, the physician and hospital interest in WPA legislation is also legitimate and deeply entrenched.

Although it is difficult to get exact numbers on how much revenue is generated by the pharmaceutical industry, considering the number of hospital births that take place in the United States, we can assume it is very significant. We do know that 99% of births occur in a hospital.[32] We also know that medication for pain relief is used in 86% of all hospital births, and epidural analgesia is used in 71% of the vaginal births.[33] That is a lot of money. Additionally, the pharmaceutical lobby is notorious for its strength and size. In 2009, the industry as a whole spent

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[23] ACNM, *Position Paper*, *supra* note 5.
[24] *Id*. at 2.
[25] *See*, *e.g.*, Roe v. Wade, 410 U.S. 113 (1973); Wis. v. Yoder, 406 U.S. 205 (1972).
[26] Amy F. Cohen, Note, *The Midwifery Stalemate and Childbirth Choice: Recognizing Mothers-to-Be as the Best Late Pregnancy Decisionmakers*, 80 IND. L.J. 849, 855 (2005).
[27] ACOG, *Memorandum in Opposition*, *supra* note 4.
[28] Hartocollis, *supra* note 1.
[29] R.E. Anderson & D.A. Anderson, *The Cost-Effectiveness of Home Birth*, 44 J. NURSE MIDWIFERY 30 (1999) (68% less).
[30] Boucher et al., *supra* note 6, at 119.
[31] *Id*.
[32] Martin, *supra* note 11, at 70.
[33] Boucher et al., *supra* note 6, at 123.

$267,973,947 on lobbying.[34] There is no doubt that an industry willing to spend that much on lobbying has a real interest in state regulation – especially the kind that could make home births (and their lack of pharmaceutical interventions) more accessible.

This brief overview of interests of key parties shows the complexity and the competitive nature of these interests. WPAs are the result of a certain kind of balance of these interests.

III. THE RIGHT TO CHOOSE A HOME BIRTH

The constitutionality of regulations prescribing WPAs has not been challenged. What follows is a review of case law that addresses the most similar legislation to get an idea of how a court might address this kind of regulation if challenged. Primarily these cases involve midwives practicing when they were specifically prohibited by law, were strictly regulated, or were practicing without the appropriate license. I look to the right to choose a home birth (or any other kind of birthing option), which has not been established in any court. Following the lead of *Roe v. Wade*, a number of courts have opined that there is no constitutional protection for the right to choose how to birth. Here, I outline the "Roe Dichotomy," as well as some of the key cases that follow which address the right to choose a birthing option.

The infamous decision in *Roe v. Wade* gave us the constitutional basis for a woman's right to choose an abortion. The Court in *Roe* specified a timeline during pregnancy to assist courts in balancing a woman's right to privacy in choosing to terminate a pregnancy and the state's interest in preserving the life of the fetus.[35] The opinion explained that, in the first trimester of a pregnancy, a woman has an undisputed right to terminate her pregnancy and to not have the state intervene in her decision – giving great deference to the woman's right to privacy.[36] Between the end of the first trimester and the "compelling point" of a pregnancy, the court gave the state an increasing ability to impede a woman's right to terminate her pregnancy, as its interest in the life of the fetus becomes more important.[37] During this time in a pregnancy, a state may regulate abortion as long as it reasonably relates to the "preservation and protection of maternal health."[38] After the fetus reaches the point of viability (the "compelling point") in a pregnancy – when a fetus may be able to "live outside the mother's womb," usually at about twenty-eight weeks, but sometimes as early as twenty-four weeks[39] – the state's interest in the life of the fetus trumps a woman's privacy right to terminate her pregnancy.[40] The state may "if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."[41]

Although *Roe* provides a strong basis for the constitutional right to privacy for a pregnant woman, when it comes to a right to the birthing option of one's choosing *Roe* seems to work against the rights of the mother. Because, under *Roe*, a woman's right to privacy comes second to the state's interest in life as her pregnancy progresses, by time she is ready to give birth, the

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[34] Center for Responsive Politics, *Lobbying: Pharmaceutical/Health Products*, OPENSECRETS.ORG, http://www.opensecrets.org/lobby/indusclient.php?lname=H04&year=2009 (last visited Nov. 15, 2010).
[35] Roe, 410 U.S. at 163.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.* at 160.
[40] *Id.* at 163.
[41] *Id*. at 164.

state's interest in the life of the fetus has overcome her own right to privacy.[42] Essentially this means that a parent – even the one carrying a child – has no guaranteed right to choose how to birth, since any state interest in the health and welfare of the child will trump the privacy right of the mother.

Intuitively, this dichotomy of *Roe* seems to counter the intentions of the Court. As Pike explains, the "reasoning is illogical, because 'undergoing abortion and employing a traditional midwife are choices concerning childbirth.'"[43] He goes on to say that the nature of the right to an abortion implies a right to control the entire birth process.[44] Because a mother can choose to end a pregnancy by abortion, it logically follows that she should be able to control how the pregnancy ends at birth. However, as it stands, the *Roe* timeline of a decreasing right to privacy as pregnancy progresses provides a strong constitutional framework for allowing increased state regulation of CNMs, including WPAs, even if it essentially eliminates home birth as an option for parents.

In *Bowland v. Municipal Court*, Bowland and a number of other women, acting as traditional midwives, were prosecuted under a statute that prohibited the unlicensed practice of medicine.[45] On appeal, the midwives raised the issue of a right to privacy by arguing that barring them from attending births, limits a woman's "liberty to choose whomever she wants to assist in the delivery of her child."[46] The court explained that the right to privacy has indeed been extended to choices related to "childrearing, marriage, procreation and abortion," citing principal cases like *Roe v. Wade*, *Loving v. Virginia*, *Griswold v. Connecticut*, and *Skinner v. Oklahoma*.[47] However, the court went on to opine that, "the right to privacy has never been interpreted so broadly as to protect a woman's choice of the manner and circumstances in which her baby is born."[48] The court relied on the *Roe* rationale to reiterate that the state's interest in life supersedes a woman's right to privacy in the third trimester of her pregnancy and that, as such, state regulation of childbirth attendants is appropriate.[49] In addressing the midwives' arguments relating to the safety of home birth (to say that the state's interest in safety is not being threatened by allowing traditional midwives to attend births), the court simply said that it is an issue for the legislature to address.[50] Under these principles, the *Bowland* Court would agree with the extension of the *Roe* rationale: that regulation of midwifery, including in regard to WPAs, is proper.

In *Leigh v. Board of Registration in Nursing*, a registered nurse appealed the decision of the nursing board to revoke her license for attending a home birth while not being licensed as a nurse-midwife.[51] The court allowed her to bring a due process claim on behalf of all pregnant women under the theory that she understood those women's right to choose how to birth and that

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[42] Michael A. Pike, *Restriction of Parental Rights to Home Births Via State Regulation of Traditional Midwifery*, 36 BRANDEIS J. FAM. L. 609, 613-14 (1998).
[43] *Id*. at 614, citing David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 MARQ. L. REV. 975, 1011 (1992).
[44] *Id*.
[45] Bowland v. Mun. Court, 556 P.2d 1081, 1081 (Cal. 1976).
[46] *Id*. at 494.
[47] *Id*.
[48] *Id*. at 495.
[49] *Id*.
[50] *Id*.
[51] Leigh v. Bd. of Registration in Nursing, 506 N.E. 2d 91, 92 (Mass. 1987).

pregnant women would be affected by the litigation.[52] Relying on *Roe* and *Bowland*, the court reiterated that upon viability, "a woman's freedom to choose must yield to the State's legitimate interest in protecting the health and safety of both the child and the mother."[53] The court went on to explicitly say that the regulation in question here – that a CNM must be licensed and must practice in a licensed facility "as part of a health care team" – "does not interfere with any 'fundamental right.'"[54] In other words, there is no fundamental guarantee for a right to choose how to birth. Again, the *Roe* line of thinking prevails.

In *Sammon* v. *New Jersey Board of Medical Examiners*, a group of women who were training to be midwives, a midwife who was not licensed in New Jersey, and a group of parents who were seeking to have home births brought a suit, claiming that the statutory requirements for licensed midwives violated their due process rights under the 14th Amendment.[55] Among other things, the statute required that in order to be licensed, a midwife must have completed 1800 hours of training and that a physician registered in New Jersey must endorse the midwifery candidate.[56] The court, here, began its analysis by looking at what standard of review was necessary in this case and by pinpointing what the statute entailed and what the plaintiffs were specifically alleging.[57] As it explained, "the interests at stake here are the interests of *Sammon* and the aspiring midwives in practicing midwifery and the interest of the parents in selecting a midwife of their choice."[58] These interests, the court said, are not the kinds of interests that are "fundamental," and, as such, do not require a standard of review higher than a rational basis review.[59] The court further explained that a statute will stand if a legitimate state interest can be identified and if that interest can be rationally related to the means chosen to further the interest.[60] Although this is not a surprise, since none of the *Roe* line of cases identified a parental right to choose birth options as fundamental, it demonstrates the continued commitment of courts to the deny choice of birthing options as a fundamental right.

However, this case did address the parents concern that the statute made it practically impossible to find a licensed midwife to attend one's home birth – something that, as will be discussed below, WPA regulations can also do. In response to this concern, the *Sammon* court said that this practical impossibility "does not serve as the basis for attacking a statute which does not prohibit home birthing but also reflects no preference for hospital deliveries."[61] In other words, a facially-neutral regulation that can be rationally related to a legitimate state interest cannot be overturned on constitutional grounds. Pike, in his article on state regulation of traditional midwifery, makes this point by saying, "Parents wishing to utilize the services of traditional midwives perhaps will have the right to do so, but it will be a hollow right, because authorized traditional midwives will no longer exist."[62]

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[52] *Id.* at 93.
[53] *Id*. at 94.
[54] *Id*.
[55] Sammon v. N. J. Bd. of Med. Exam'rs, 66 F.3d 639 (3d Cir. 1995).
[56] *Id*. at 641.
[57] *Id*. at 643-44.
[58] *Id*. at 644-45.
[59] *Id*. at 645.
[60] *Id*.
[61] Sammon, 66 F.3d at 647.
[62] Pike, *supra* note 42, at 621.

Hunter v. *State of Maryland* further solidifies the precedent in this area of law. Similar to *Bowland*, *Leigh*, and *Sammon*, in *Hunter,* a suit was brought against a midwife practicing without a license who was able to bring up the parents' right to privacy. The court in this case explicitly stated that "where to give birth and whom to call on for assistance" is not a fundamental right.[63] The court went on to explain that the regulation that prohibited the practice of nursing without a license did not violate the parents' right to use the services of a midwife or have a home birth; it simply "regulates who may engage in the practice of midwifery."[64] As was also seen in the earlier cases, the court decided that the statute is rationally related to the health and welfare of the mother and child by ensuring that those who practice midwifery are "properly trained."[65]

These cases demonstrate the well-established principle that a statute which regulates midwifery, so long as it is rationally related to a legitimate state interest, is going to be upheld. As demonstrated in *Sammon*, such a statute will be upheld even if the statute makes it practically impossible to have a home birth, as long as the statute does not prohibit home birth explicitly. For WPA legislation, this means that, under the theory of the due process right to privacy, a constitutional challenge is highly likely to fail. WPA regulations, similar to the cases above, create a requirement for practicing midwifery and do not prohibit home birth outright. Also important is that these regulations easily fit into the "health and welfare of the mother and child" argument that was used in each of these cases. Thus, although it has not been challenged, this line of cases supports the notion that WPA legislation is legal.

IV. HOW THE LEGISLATION WORKS

Although WPA legislation is facially-neutral, its practical implications look more like a prohibition on home birth. The story of New York has been in the press recently and acts as a good model to observe how this kind of legislation actually *affects* people and results in reproductive oppression.

New York was the site of the first CNM practice in 1930 and it is home to the largest population of CNMs and certified midwives in the country (about 1000 in total).[66] However, in New York, before the closure of St. Vincent's Hospital, only thirteen CNMs were legally able to practice home births.[67] Although there may be several reasons for the small number of home birth midwives, it is undeniable that the WPA requirement for being licensed in New York had a very real impact.[68] Under New York's Professional Midwifery Practice Act, a licensed midwife had to have a WPA with a physician that was licensed to practice obstetrics, a physician that practiced obstetrics at a licensed hospital, or a hospital that provided obstetrics through a licensed physician who had privileges there.[69] The agreement was to: outline a plan for "consultation, collaboration, referral and emergency medical obstetrical coverage;" provide a

[63] Hunter v. State, 676 A.2d 968, 975 (Md. Ct. Spec. App. 1996).
[64] *Id*. at 160.
[65] *Id*. at 161.
[66] ACNM, *Certified Nurse-Midwives & Certified Midwives in New York*, ACNM ONLINE, (2009) http://www.midwife.org/siteFiles/legislative/New_York_09.pdf (last visited Nov. 15, 2010).
[67] Hartocollis, *supra* note 1.
[68] *See* Pike, *supra* note 42, at 620, 623; Hartocollis, *supra* note 1; ACNM, *Position Paper*, *supra* note 5.
[69] N.Y. EDUC. LAW § 6951 (McKinney 2010).

guideline for what constitutes a high-risk pregnancy; and define a "mechanism for dispute resolution," including that the judgment of an "appropriate physician shall prevail."[70]

Because of St. Vincent's Hospital's sympathetic relationship with midwives, seven of the thirteen CNMs who practiced home birth in New York had WPAs with it.[71] When the hospital closed its doors at the end of April, 2010, due to bankruptcy, those seven midwives lost their WPAs.[72] Despite efforts before the closure, none of these midwives were able to secure a WPA from any other physician or hospital.[73] Not being able to satisfy the requirements of the Act, these midwives were no longer legally allowed to practice.

Although, the Professional Midwifery Practice Act's language was facially-neutral because it only regulated people who wished to practice midwifery in New York, its practical implication was a serious reproductive oppression that impeded a parent's right to choose a home birth. First, this Act resulted in reproductive oppression for the parents who were already receiving care from a midwife, whom, through no fault of her own, had her WPA revoked – as in the case of the midwives with WPAs with St. Vincent's. It essentially reversed these parents' choices to have a home birth after already deciding on and beginning planning for one with a licensed midwife. After all, these parents' only options would have been to proceed with the home birth and risk punishment for their midwife, have an unattended home birth, or give birth in a hospital or birth center. Second, the Act resulted in reproductive oppression for future parents by limiting the number of midwives who were legally able to perform home births in New York. Because of physicians' reluctance to enter into WPAs with home birth midwives, the requirement for the agreement created a practical impossibility, as the parents in *Sammon* were expressing.

New York's story is not unusual. In California, 111 midwives were licensed under the California Licensed Midwifery Act of 1993.[74] However, only one was able to find a supervising physician, a requirement in California law in order to attend home births. [75] In fact, only about 150 CNMs perform home births in the United States.[76] It is generally understood in the midwifery community that this is in large part due to the requirement for WPAs.[77]

V. SEEKING REPRODUCTIVE JUSTICE

A. Legal possibilities

The case law, as illustrated above, is very clear that a facially-neutral statute that is rationally related to a legitimate state interest will withstand constitutional due process privacy challenges. But, are there other possible legal claims to be made against WPA legislation? Here, I offer two: (1) birthing rights as parental authority, and (2) birthing rights as bodily integrity.

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[70] *Id*.
[71] Hartocollis, *supra* note 1.
[72] *Id*., Ed Pilkington, *New York Midwives Lose Right to Deliver Babies at Home*, GUARDIAN.CO.UK (2010), http://www.guardian.co.uk/lifeandstyle/2010/may/14/home-births-new-york-midwives (last visited Nov. 15, 2010).
[73] *Id*.
[74] Tovino, *supra* note 7, at 95.
[75] *Id*.
[76] Jill Cohen, *The Homebirth Choice*, MIDWIFERY TODAY ONLINE (2008), http://www.midwiferytoday.com/articles/homebirthchoice.asp (last visited July 27, 2010).
[77] *Id*.

The right to parent as one chooses is well established in constitutional law under the right to privacy. Most notably, in *Wisconsin* v. *Yoder*, Amish parents sought not to enroll their children in public or private schools after grade 8, despite a statute requiring them to be in school until the age of 16.[78] In this case, the Court held that the statute in question "unreasonably interfere[d] with the liberty of the parents and guardians to direct the upbringing and education of children under their control."[79] Although this decision hinged primarily on the fact that the decision not to send their children to secondary school was related to the Amish tradition and, therefore, a group's religious freedom, the *Yoder* case did lay the groundwork for a right to parental authority.

A more recent Supreme Court case, *Troxel* v. *Granville*, explicitly established the right to parental authority. In *Troxel*, paternal grandparents petitioned for visitation under a Washington statute that permitted any person to petition for visitation.[80] The Court held that the statute was unconstitutional as it violated the mother's 14th Amendment right to due process.[81] The Court explained that "[t]he liberty interest at issue in this case-the interest of parents in the care, custody, and control of their children-is perhaps the oldest of the fundamental rights recognized by this Court."[82]

This overt statement that the right to parent is fundamental opens the door for due process protection for other elements of parenting. Cohen makes a compelling argument that pregnancy is indeed parenting.[83] She explains that motherhood is a "continuum," rather than beginning at birth.[84] For Cohen, "birth marks a new phase in [the mother-child] relationship, not the beginning of that relationship."[85] The argument is a logical one: while pregnant, the mother makes choices on behalf of the unborn child, from nutrition to medical care.[86] And that is not to mention all the decisions parents make in planning for their future children; for example, where they will live, who will care for them, and who will be their medical care providers. Further, using *Roe* logic, as the fetus reaches viability and the state begins to have an interest in its life and health, a woman choosing to give birth is essentially agreeing to take parental responsibility (at least until birth). As such, there is an argument to be made, that at least upon viability, a mother is parenting her unborn child.

Under this theory, it is possible that an attack on WPA legislation, and the practical impossibility to choose a home birth in many instances, might be successful. If a mother has a fundamental right to parent her unborn child, any statute affecting where and how she chooses to birth that child will be subject to strict scrutiny, rather than the rational basis of review. As such, the regulation would have to show that it could not protect a compelling government interest in a less restrictive way. Under this review, WPA legislation is significantly less likely to withstand the challenge.

The right to bodily integrity is the other theory under which WPA legislation might be able to be successfully challenged. The tragic case of *In re: A.C.* creates a springboard for

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[78] Wis. v. Yoder, 406 U.S. 205 (1972).
[79] *Id.* at 233.
[80] Troxel v. Granville, 530 U.S. 57 (2000).
[81] *Id*.
[82] *Id*. at 65.
[83] Cohen, *supra* note 26, at 864-65.
[84] *Id*. at 865.
[85] *Id*. at 866.
[86] *Id*.

extending the right to bodily integrity to choice of birthing options. *In re: A.C.* involved a terminally-ill woman who was twenty-six weeks pregnant and, after an emergency hearing, was ordered to have a caesarian section despite her lack of consent to the surgery.[87] The court hearing the request for the court-ordered surgery relied on the understanding that a state's interest in the life of the fetus superseded the right of A.C to bodily integrity.[88] In deciding *In re: A.C.*, the court established that every person has a right to accept or refuse medical treatment, and that a court must abide by a person's wishes in relation to that right unless there is a "truly extraordinary" reason to overrule those wishes.[89]

In relating this to WPA legislation that impedes a parent's ability to choose a home birth, if a parent wishes to have a home birth, she is choosing to refuse any elective medical intervention in the birthing process. By limiting her ability to have a home birth through unnecessary regulation, like WPAs, a state is essentially denying her a right to refuse medical treatment without a "truly extraordinary" reason. With 94% of all hospital births having some kind of medical intervention[90] and many hospitals having policies requiring interventions like electronic fetal monitoring, a woman's ability to refuse medical treatment in a hospital setting is a practical impossibility. Amending legislation is hardly a "truly extraordinary" reason to overrule a woman's wishes. As such, there is an argument, although, recognizably, a bit of a long shot, to be made that WPA legislation should not stand under the theory of bodily integrity.

B. Legislative possibilities

A number of the courts have recommended that changes to restrictive midwifery laws need to come from the legislatures.[91] In fact, some states already have amended or retracted WPA legislation, recognizing the reproductive oppression it creates. Licensing of midwives has a number of layers: licensing by the state and, in forty-eight states and territories, by the national American College of Nurse-Midwives (ACNM).[92] Because midwives have to adhere to strict protocols to be licensed by the ACNM, often state requirements for licensing are redundant.[93] As such, some states are pushing for regulatory change on the basis that CNMs already have to establish collaborative relationships with physicians and report to the ACNM Board on these relationships.[94] Very recently, New Jersey and Maryland initiated changes to their rules that eliminate the need for WPAs with physicians on this theory.[95] In New Jersey, the legislation now requires that a midwife only submit the identity of her physician affiliates upon request.[96] Maryland now requires a midwife to create a plan for consultation, collaboration, and referral, but that plan does not need to be signed by a physician nor submitted.[97] Most recently, New

[87] In re: A.C., 573 A.2d 1235 (D.C. 1990).
[88] *Id*. at 1240.
[89] *Id.* at 1247.
[90] Boucher, *supra* note 6, at 123.
[91] *See* Bowland v. Mun. Court, 556 P.2d 1081, 1089 (Cal. 1976), *and* Hunter v. State, 676 A.2d 968, 976 (Md. Ct. Spec. App. 1996).
[92] Reed & Roberts, *supra* note 2, at 137.
[93] ACNM, *Position Paper, supra* note 5.
[94] *Id*.
[95] ACNM, *State Legislative and Regulatory Developments*, *supra* note 3.
[96] 42 N.J.Reg. 1213(b) (June 21, 2010), *available at* http://www.midwife.org/siteFiles/legislative/NJ_Collaborative_Practice_June_21_2010.pdf.
[97] ACNM, *State Legislative and Regulatory Developments*, *supra* note 3.

York's Midwifery Modernization Act was signed into law on July 30, 2010, by the governor after being passed by both the House and Senate of the legislature.[98] The Act will remove all physician signatory requirements and instead require "mechanisms for consultation, collaboration, and transfer of care when needed."[99]

Despite these exciting changes and the requirements by the ACNM for collaborative relationships with physicians, most states maintain WPA legislation that continues to create reproductive oppression for its citizens. Although this confirms the need to work to pressure state governments for immediate regulatory change, the theory of redundancy in licensing requirements creates a framework for working for this change.

CONCLUSION

State WPA legislation pervades the United States. Requiring a midwife to have a physician or hospital's signature on some kind of WPA creates significant barriers to midwives being able to practice home births. As such, parents' right to choose a home birth is impeded and reproductive oppression occurs. Although case law, based on *Roe v. Wade* rationale, is fervent that parents do not have a fundamental right of privacy to birth as one chooses, an argument that birthing options are part of a fundamental right of parental authority could be explored in an effort to protect a right to birthing choice. Additionally, a convincing argument could be made that the right to bodily integrity should be extended to include a right to home birth. However, it is clear that working for legislative change to WPA rules will be the most effective way to eliminate the reproductive oppression that the legislation creates. And, considering the requirements for physician collaboration that almost all midwives are subject to under the ACNM licensing, pressuring legislatures to remove the WPA requirement is logical. In other words, there is hope! Reproductive justice is attainable – at least when it comes to eliminating the piece of reproductive oppression that is caused by WPA legislation.

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[98] *Id*.

[99] ACNM, *American College of Nurse-Midwives Urges Passage of the Midwifery Modernization Act*, ACNM ONLINE, http://www.midwife.org/siteFiles/news/NYMidwiferyModernizationAct.pdf (last visited Nov. 15, 2010).