NOTE

Disasters Lying in Wait: Over-Medicalization of the Birthing Process and the Lifesaving Practice of Midwifery

FULTON WALD*

TABLE OF CONTENTS

* Georgetown Law, J.D. 2022; Kenyon College, B.A. 2017. I'm forever grateful to the incredible *GLJ* team whose feedback and edits transformed this paper. Particularly, Madeline Emmett, Kristen Green, Annie Dang, Radiance Campbell, and David Offit whose expertise with words (and the *Bluebook*) knows no bounds. Thank you to Rosie Gilroy, Kate Dellis, and Camille Baptista for their essential feedback. Thank you to Ayres Stiles-Hall at Concord Academy, whose encouragement has led me to pursue writing with confidence—this may be my first publication, but hopefully not my last. And thank you to Tompkins, whose patience, support, and kindness could never be reduced to words. The world is better with you in it. Finally, to the strongest woman I know: my mom, a writer and artist who raised my sister and me all on her own. You taught us to read and write with passion. While my name may be on this paper, every word I have ever written can be attributed to you.

> A midwife looks at a pregnant woman and sees a beautiful, normal, physiological, wonderful event about to happen . . . . An obstetrician looks at a pregnant woman and sees a disaster lying in wait for them. If you've got these two health care professionals working together as a team and meeting in the middle, what you end up with is really good health care.
>
> — Sally Collins, Associate Professor of Obstetrics, University of Oxford[1]

INTRODUCTION

In the United States, physicians preside over 90% of births, yet the country paradoxically has the worst maternal and infant mortality rates of any wealthy nation, with risks up to three times higher for Black and Indigenous American women.[2] This

1. Kate Womersley, *Why Giving Birth Is Safer in Britain Than in the U.S.*, PROPUBLICA (Aug. 31, 2017, 8:00 AM), https://www.propublica.org/article/why-giving-birth-is-safer-in-britain-than-in-the-u-s [https://perma.cc/E74H-FNC5].

2. *See* Sandi Doughton, *The Case for Midwives: Washington State Leads the Nation in Midwifery Care*, SEATTLE TIMES (Mar. 15, 2020, 7:00 AM), https://www.seattletimes.com/pacific-nw-magazine/the-case-for-midwives-washington-leads-the-nation-in-midwifery-care-giving-women-another-childbirth-option/ ("[There are] rising levels of complications and premature birth; C-section rates more than twice the recommended level; a looming shortage of obstetricians; and sky-high spending."); *see also* Christopher Ingraham, *Our Infant Mortality Rate is a National Embarrassment*, WASH. POST (Sept. 29, 2014, 10:38 AM), https://www.washingtonpost.com/news/wonk/wp/2014/09/29/our-infant-mortality-rate-is-a-national-embarrassment/ (citing a Centers for Disease Control report finding that the United States has a "higher infant mortality rate than any of the other 27 wealthy countries").

This Note acknowledges that not all pregnant people are women, nor are all people who are able to become pregnant women. By referring broadly to "healthcare" and "patients" wherever possible, we remember that many people encounter the obstetric and midwifery care systems discussed in this Note. However, in line with the Trans Journalists Association's guidelines, this Note retains gender-specific language (e.g. "pregnant women") if discussing a study that only includes cisgender women. It also retains "maternal mortality" as a term of art. *See* Statement, Trans Journalists Ass'n, TJA Best Practices

problem has only worsened over time—maternal mortality rates in the United States have almost doubled in the last twenty years, with 60% of these deaths estimated to be preventable.[3] A myriad of issues contribute to these mortality rates. The U.S. for-profit healthcare system creates high financial barriers to access and wealth inequality gaps are at an all-time high; people of color in the United States are disproportionately impacted by poverty, and this results in people of color disproportionately dying in childbirth due to structural barriers inhibiting their access to prenatal or postnatal care. These mortality rates are indicative of the nation's long history of reproductive violence against people of color, particularly Black women. From its legacy of slavery to forced sterilizations and the overturning of *Roe v. Wade*,[4] U.S. institutions continue to harm people of color. While many different tactics on various institutional levels are needed to combat these issues, this Note highlights midwifery as an essential part of the solution to high U.S. maternal and infant mortality rates.[5]

In Europe, 70% of births involve midwives assisting in a hospital setting; however, the U.S. maternal mortality rate is three times higher than the United Kingdom (UK)'s and eight times higher than Iceland's, the world's leader in maternal survival rates.[6] If the United States has comparatively one of the highest rates of medical professionals overseeing births, why are its survival rates so abysmal in comparison? In the UK, midwives preside over more than half of all births.[7] In Nordic countries and France, midwives are even more commonplace, overseeing the majority of births.[8] U.S. citizens have accordingly increased usage of midwives over the past few decades. Between 2007 and 2015, the percentage of out-of-hospital births rose from 0.9% to 1.5%, with 63.1% of out-of-hospital births in 2015 occurring at home and 30.9% occurring in midwife-attended freestanding birth centers.[9] However, these numbers are nowhere near comparable to those in Europe. If the United States made a concerted effort to match Europe's

for Trans-Inclusive Language in Abortion Coverage (May 5, 2022) (available at https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:b4cff98c-6335-3157-a972-ef08d07b8f1f#pageNum=1).

3. *See* Sofia Jeremias, *The Rise of Midwives in Rural America*, DESERET NEWS (Sept. 2, 2021, 12:00 AM), https://www.deseret.com/2021/9/1/22650628/the-rise-of-midwives-in-rural-america-nurse-midwifery-maternal-death-rate-medicine [https://perma.cc/84Y2-MBX7].

4. *See* Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242 (2022).

5. This Note does not pretend to address all aspects of U.S. maternal and infant mortality rate disparities. Rather, this Note centers the specific crisis of Black women's birth outcomes in Southern states. Additionally, while a focus on Southern Black women of course includes Southern Black disabled women, trans people, and other intersecting identities, this Note does not intend to address the unique challenges these Americans face in accessing pregnancy care—instead, the author invites future research and scholarship in the area.

6. *See* Jessica Brown, *The Fight for Birth: The Economic Competition That Determines Birth Options in the United States*, 52 U.S.F. L. REV. 1, 6 (2018).

7. *See id.* at 7.

8. Doughton, *supra* note 2. Even Kate Middleton, Princess of Wales, gave birth to her children via midwife. *Id.*

9. *See* Linda Levinson, *Solving the Modern Midwife Problem: The Case for Non-Nurse Midwifery Legislation in Pennsylvania*, 91 TEMP. L. REV. 139, 140–41 (2018).

midwifery practices, this could result in 280,000 fewer maternal deaths and two million fewer newborn deaths per year by 2035.[10]

In conjunction with midwife utilization, most developed countries with better birth rates have free or low-cost access to prenatal care.[11] While midwives integrate easily into European universal healthcare systems, the United States excludes them from maternity care, mainly for financial reasons unique to its high-cost insurance system.[12] Thus, to embrace midwives, the United States must change its approach to maternity care and its approach to healthcare as a whole. This Note will consider the prohibitively expensive U.S. healthcare institution, especially for Black patients, ultimately making two claims: (1) to combat prohibitively expensive maternity care costs in the United States, midwifery care should be revived and expanded; and (2) the most realistic way to meet this goal is for the United States to revise and broaden Medicaid's coverage of maternal care.

Part I of this Note details this country's history of abuse and repression of Black women's reproductive autonomy. It discusses how this history of abuse impacts modern medicine, then discusses Alabama, a state with a large Black community and some of the highest maternal mortality rates in the country. This Part offers information on why Alabama is such a dangerous state in which to give birth and how midwives could contribute to safer birthing options for patients, particularly Black patients. Part II then focuses on licensing and state regulation issues that restrict midwives from both certification and practice, creating barriers that prevent midwives from caring for patients. This Part highlights Pennsylvania and Washington as two states with different approaches to midwifery and assesses the success of each state in integrating midwives into the medical system. Part III addresses how economics fits into the aforementioned midwifery issues. Hospitals and physicians have a history of excluding midwives from practice using anticompetitive methods; this Part offers case law and Federal Trade Commission (FTC) investigations to discuss how midwifery practices can gain legal protection. Part IV gives public policy suggestions, particularly that universal healthcare would create the safest and most equitable birthing environments for Americans. However, because the United States will likely not switch to universal healthcare in the near future, this Part offers other solutions that could work in conjunction with the current U.S. healthcare system to best integrate midwives into maternity care, especially for Black people in the South.

I. THE DANGERS BLACK PATIENTS FACE WITHIN HEALTHCARE INSTITUTIONS

The U.S. medical system neglects and abuses Black patients and their babies. This creates an environment that normalizes the systematic victimization of Black people by hospitals, resulting in Black patients being significantly more

10. Jeremias, *supra* note 3.
11. Brown, *supra* note 6.
12. *See infra* Section II.A.

likely to die during childbirth than white patients. While this Note discusses the dangers of childbirth as a whole, this Part highlights historic gender-based violence against Black cis-women and the systemic barriers Black patients specifically face when seeking healthcare, adding context to the American healthcare system's failure to provide for patients.

A. BACKGROUND

Throughout its history, the United States has repressed and targeted Black women's reproductive autonomy.[13] In 1808, a federal ban on the importation of enslaved people went into effect, forcing U.S. enslavers to rely on domestic births.[14] This heightened enslavers' interest in enslaved Black women's reproduction—the ability of enslaved women to have children meant that enslavers could continue expanding their workforces.[15] However, pregnant enslaved women still faced equally harsh labor conditions and punishments as their nonpregnant counterparts.[16] Because enslavers saw value in the ability to reproduce, they were enraged when miscarriages or stillbirths occurred—even though the inhumane treatment of pregnant enslaved women was likely often the cause of the miscarriage or stillbirth.[17] This interest in enslaved women's reproductive ability led to medical experimentation on enslaved women.[18] Reliant on domestic births, enslavers focused on producing healthy enslaved infants without improving the living or labor conditions of the enslaved mothers, and thus enslavers allowed white physicians to perform gynecological examinations and experiments on enslaved women in an attempt to bring more pregnancies to term.[19] This influenced the U.S. slave market, where "slavery, medicine and medical publishing formed a synergistic partnership" particularly in the field of gynecology.[20]

In the 1840s, J. Marion Sims, later known as "the father of American gynecology," began performing experiments on Black enslaved women in Alabama.[21] Over the course of four years, he performed surgeries without anesthesia on

13. *See, e.g.*, Danielle Thompson, *Midwives and Pregnant Women of Color: Why We Need to Understand Intersectional Changes in Midwifery to Reclaim Home Birth*, 6 COLUM. J. RACE & L. 27, 40–41 (2016) (detailing the U.S. history of utilizing eugenics, negative stereotypes, and forced sterilizations to control the reproductive rights of communities of color).

14. *See* Kathleen Bachynski, *American Medicine Was Built on the Backs of Slaves. And It Still Affects How Doctors Treat Patients Today*, WASH. POST (June 4, 2018, 6:00 AM), https://www.washingtonpost.com/news/made-by-history/wp/2018/06/04/american-medicine-was-built-on-the-backs-of-slaves-and-it-still-affects-how-doctors-treat-patients-today/.

15. *See* DEIRDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY 43–44 (2017).

16. *See id.*

17. *See id.* at 43 (recounting the Alabama case, *Athey v. Olive*, 34 Ala. 711 (1859), where an enslaver sued the man who had sold him a pregnant enslaved woman after the baby died and blamed the woman for producing a stillborn, despite the "tremendous amount of stress" she endured due to being removed "from her home to a new slave community").

18. *See id.* at 42–43.

19. *See* Bachynski, *supra* note 14.

20. *Id.*

21. *See* Annabel Sowemimo, *The Racist and Unethical Origins of Modern Gynecology*, CLUE (Jan. 10, 2021), https://helloclue.com/articles/culture/the-racist-and-unethical-origins-of-modern-gynecology

enslaved women,[22] with one woman, Anarcha,[23] being subjected to thirty operations.[24] Through these experiments, Sims designed the vaginal speculum and developed a treatment for vesicovaginal fistula (VVF).[25] The treatment for VVF was particularly valuable to enslavers, as the condition previously "threatened [an enslaved] woman's ability to perform hard labor as well as her future reproductive capacity."[26] These experiments laid the foundation for modern gynecology.

By the early twentieth century, the practice of eugenics was gaining popularity in the United States.[27] Eugenics promoted population control through the "reproduction of 'good stock' while discouraging or prohibiting the reproduction of 'bad stock.'"[28] This led to American eugenicists endorsing regulations against Black and certain immigrant populations, claiming that these groups were mentally inferior,[29] and prompted twenty-four states and Washington, D.C., to ban "genetically defective" marriages by 1913.[30] "[B]y 1935, thirty-three states had laws allowing eugenics-based forced sterilizations; and by 1940, thirty states had codified interracial marriage bans."[31] At this time, the majority of forced sterilizations were performed by doctors on individuals in mental institutions.[32]

[https://perma.cc/7MWK-HMZD]; Keith Wailoo, *Historical Aspects of Race and Medicine: The Case of J. Marion Sims*, 320 J. AM. MED. ASS'N 1529, 1529 (2018).

22. Hidden Brain, *Remembering Anarcha, Lucy, and Betsey: The Mothers of Modern Gynecology*, NPR, at 08:45 (Feb. 7, 2017, 12:00 AM), https://www.npr.org/2017/02/07/513764158/remembering-anarcha-lucy-and-betsey-the-mothers-of-modern-gynecology [https://perma.cc/R2VF-5FP4] (noting that Sims later treated white women for vesicovaginal fistula after he "perfected" the technique on the bodies of enslaved Black women, but gave white women anesthesia).

23. Although this Note refers to Anarcha as a woman, she was only seventeen years old at the time the experimentation began. *Id.* at 05:00.

24. *See* Sowemimo, *supra* note 21; Bachynski, *supra* note 14 (stating that Anarcha, and two other enslaved women, Lucy and Betsey, were all subjects of these experiments and medical assistants to Sims); *see also* Hidden Brain, *supra* note 22, at 18:00 (detailing medical myths from the slave era and remembering Anarcha, Lucy, and Betsey as "the Mothers of Modern Gynecology" due to their work and research in the field of gynecology, for which they never received recognition).

25. *See* Bachynski, *supra* note 14 (noting that modern day public outcry has highlighted the inhumanity of Sims' experiments, with a statue of Sims removed from Central Park in New York City in 2018); *see also* Hidden Brain, *supra* note 21, at 03:37 (VVF is a condition where "there is an opening between the vagina and [] the bladder or the vagina and the rectum" that usually happens after traumatic childbirth).

26. Bachynski, *supra* note 14.

27. *See* Thompson, *supra* note 13, at 39.

28. *Id.* (citing DOROTHY ROBERTS, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 59–60 (1997)).

29. *See id.* ("American eugenicists and eugenists bolstered these arguments in favor of regulating Black and certain immigrant populations by claiming that their low IQ test scores were indicative of their inherent intellectual and mental inferiority to Whites. This argument, however, ignored the possibility that, at the time, low IQ tests scores among Black Americans and certain immigrants instead resulted from their systematic denial of access to education." (footnotes omitted)).

30. *Id.* (quoting ROBERTS, *supra* note 28, at 65).

31. *Id.* (footnotes omitted).

32. *See* Philip R. Reilly, *Eugenics and Involuntary Sterilization: 1907–2015*, 16 ANN. REV. GENOMICS & HUM. GENETICS 351, 356 (2015).

In the wake of World War II, however, forced sterilizations began to decline in most of the United States, but some Southern and Midwestern states, primarily North Carolina, continued the practice via state eugenics boards or a nonprofit called Birthright, which campaigned for the sterilization of young, poor, rural, mainly Black women, who were neither intellectually disabled nor institutionalized.[33] The state eugenics boards supported the sterilization program through the 1960s until Medicaid began funding nonconsensual sterilizations in the 1970s.[34] For example, in North Carolina, government or nonprofit actors sterilized 7,600 people in total between 1929 and 1974, disproportionately targeting Black and Indigenous women.[35] In fact, "from 1950 to 1966, Black women were sterilized at more than three times the rate of white women and more than 12 times the rate of white men."[36] In total, twentieth-century American government officials, social workers, and nonprofits likely subjected over 80,000 people who were either imprisoned, institutionalized, immigrants, queer, Indigenous, of color, or low-income to forced sterilization.[37]

The U.S. legacy of slavery, eugenics, and sterilization still informs the way Black pregnancies are viewed by medical providers and legislators today. Dorothy Roberts writes that "white childbearing is generally thought to be a beneficial activity . . . [.] Black reproduction, on the other hand is treated as a form of *degeneracy*."[38] This has led to modern stereotypes such as the "'welfare queen' knowingly over-producing children at the expense of the lawful, White tax-payer, as well as the negligent drug-addicted mother who irresponsibly and cruelly reproduces 'crack babies.'"[39] Black pregnancies are thus considered "dangerous" and "in need of control."[40] This stereotyping upholds racial, gender, and class biases, which "serves the interests of white supremacy."[41]

---

33. *See id*. at 359.

34. *See* Alexandra Stern, *Forced Sterilization Policies in the US Targeted Minorities and Those with Disabilities – and Lasted into the 21st Century*, U. MICH. INST. FOR HEALTHCARE POL'Y & INNOVATION (Sept. 23, 2020), https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lasted-21st [https://perma.cc/RD5A-PNHT]; *see also* Linda Villarosa, *The Long Shadow of Eugenics in America*, N.Y. TIMES MAG. (June 8, 2022), https://www.nytimes.com/2022/06/08/magazine/eugenics-movement-america.html (detailing the far-reaching impacts of the forced sterilizations of Black women in the South, particularly the story of the Relf sisters, who were sterilized in Alabama in 1973).

35. *See* Villarosa, *supra* note 34.

36. Stern, *supra* note 34.

37. *See* Kevin Begos, *The American Eugenics Movement After World War II (Part 1 of 3)*, INDY WK. (May 18, 2011, 4:00 AM), https://indyweek.com/news/american-eugenics-movement-world-war-ii-part-1-3/. [https://perma.cc/5HWM-FJ44] (noting that unethical sterilization practices still survive today, with one North Carolina nonprofit offering persons with substance abuse disorders $300 to be sterilized); *see also* Felicia O. Casanova, *Women of Color's Reproductive Perils Reproduced*, 20 CONTEXTS 34, 59 (2021) (detailing how ICE medical practices of "performing questionable hysterectomies without informed consent or warranted health concerns . . . echo the past sterilization practices in the U.S. against Black and Brown women").

38. Thompson, *supra* note 13, at 38 (quoting ROBERTS, *supra* note 28, at 9) (emphasis in original).

39. *Id*. at 37.

40. *Id*. at 38.

41. *Id*. (quoting ROBERTS, *supra* note 28, at 5).

B. MODERN IMPACT OF THE U.S. LEGACY OF REPRODUCTIVE RACISM

Black women are more likely to die from pregnancy than any other racial group and are three to four times more likely to experience pregnancy-related death than white women.[42] This alarming mortality rate can be attributed to a variety of factors, including, but not limited to, the U.S. history of slavery and racism regarding reproductive rights, high financial barriers to obtaining insurance, institutional racism which heightens the likelihood that Black Americans will suffer from preventable diseases and chronic health conditions, and the problematic financial barriers specifically around prenatal care.[43]

This issue is especially apparent in the modern South, where a majority of Black Americans live.[44] Because Southern states have some of the highest barriers to Medicaid access, they maintain worse birth outcomes for Black women.[45] Black women are also disproportionately impacted by poverty in the South.[46] While higher poverty rates are associated with higher maternal mortality rates for women of all races, poverty impacts Black women at more than twice the rate of white women, creating disproportionately worse birth outcomes for Black women.[47] Additionally, due to high barriers to abortion access in these states, most of which have restricted abortion following the overturning of *Roe*,[48] Black women are more likely to have unintended pregnancies due to inadequate access to contraceptives.[49] People with unintended pregnancies must bear significant

42. *See* NAT'L P'SHIP FOR WOMEN & FAMS., BLACK WOMEN'S MATERNAL HEALTH: A MULTIFACETED APPROACH TO ADDRESSING PERSISTENT AND DIRE HEALTH DISPARITIES 2 (2018), https://www.nationalpartnership.org/our-work/resources/health-care/maternity/black-womens-maternal-health-issue-brief.pdf [https://perma.cc/C6FE-YMR7].

43. *See id*. at 1.

44. *See* Christine Tamir, Abby Budiman, Luis Noe-Bustamante & Lauren Mora, *Facts About the U.S. Black Population*, PEW RSCH. CTR. (Mar. 25, 2021), https://www.pewresearch.org/social-trends/fact-sheet/facts-about-the-us-black-population/ [https://perma.cc/STL8-5XCF] ("Regionally, the highest concentration of Black people in the U.S. in 2019 is in the South. More than half (56%) live there, while 17% live in the Midwest, 17% live in the Northeast and 10% live in the West."); *Maternal Mortality Rate By State 2022*, WORLD POPULATION REV., https://worldpopulationreview.com/state-rankings/maternal-mortality-rate-by-state [https://perma.cc/B7SH-YUAE] (last visited Aug. 25, 2022) (listing the top ten states with the highest maternal mortality rates—out of those ten, seven are Southern states: Louisiana, Georgia, Arkansas, Alabama, Missouri, Texas, and South Carolina).

45. *See* NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 3; WORLD POPULATION REV., *supra* note 44; *see also* Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women*, 48 J. L., MED. & ETHICS 506, 512–13 (2020) (detailing the racial implications of unexpanded Medicaid, particularly in Southern states, and how this creates high barriers to access).

46. *See* CTR. FOR REPROD. RTS., RESEARCH OVERVIEW OF MATERNAL MORTALITY AND MORBIDITY IN THE UNITED STATES 3–4 (2016), https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_MH_TO_ResearchBrief_Final_5.16.pdf [https://perma.cc/QBH5-6J8M].

47. *See id*. at 4.

48. *See* Sarah Knight, Wynne Davis, Kristin Gourlay, Carmel Wroth, Haidee Chu & Katie Daugert, *Here's Where Abortions Are Now Banned or Severely Restricted*, NPR (Sept. 26, 2022, 4:02 PM), https://www.npr.org/sections/health-shots/2022/06/24/1107126432/abortion-bans-supreme-court-roe-v-wade [https://perma.cc/NMX3-ZMD8].

49. *See* Michele Troutman, Saima Rafique & Torie Comeaux Plowden, *Are Higher Unintended Pregnancy Rates Among Minorities a Result of Disparate Access to Contraception?*, 5 CONTRACEPTION & REPROD. MED., no. 16, Oct. 2020, at 1 (2020).

financial costs to access care as they face an environment that actively restricts access to prenatal care for those in poverty and provides few realistic options for medical care during pregnancy.

However, economic factors alone do not fully account for Black women's birth outcomes. In fact, a "black woman with an advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education."[50] This indicates that Black women's pregnancy complications are more than a side effect of low financial means. As one researcher commented, "[e]veryone always wants to say that it's just about access to care and it's just about insurance, but that alone doesn't explain it[.]"[51] In fact, pregnancy complications such as uterine tumors that cause hemorrhaging and preeclampsia impact Black women at notably higher rates.[52] Several researchers have now attributed these issues to a phenomenon called "weathering," unique to the United States—weathering, the chronic impact of socioeconomic disadvantages and racial discrimination, accelerates aging for Black women in comparison to their white counterparts.[53] This results in a disproportionate amount of Black babies with fatal health issues. Black babies are now 49% more likely to be born prematurely and twice as likely to die before their first birthday as white children,[54] a racial disparity larger today

50. *See* Linda Villarosa, *Why America's Black Mothers and Babies Are in a Life-or-Death Crisis*, N.Y. TIMES MAG. (Apr. 11, 2018), https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

51. Maya Salam, *For Serena Williams, Childbirth Was a Harrowing Ordeal. She's Not Alone.*, N.Y. TIMES (Jan. 11, 2018), https://www.nytimes.com/2018/01/11/sports/tennis/serena-williams-baby-vogue.html.

52. *See* Villarosa, *supra* note 50 (finding that "pre-eclampsia and eclampsia (seizures that develop after pre-eclampsia) are 60 percent more common in African-American women and also more severe").

53. *See* NAT'L P'SHIP FOR WOMEN & FAMILIES, *supra* note 42; Villarosa, *supra* note 50. A 1997 study bolsters the theory of weathering as unique to the United States. The study found that babies born to new immigrants from West African nations weighed more than their Black American-born counterparts, and they were similar in size to white babies; "[i]n other words, they were more likely to be born full term, which lowers the risk of death." *Id.* In 2002, the same researchers found that "[t]he daughters of African and Caribbean immigrants who grew up in the United States went on to have babies who were smaller than their mothers had been at birth, while the grandchildren of white European women actually weighed more than their mothers had at birth. It took just one generation for the American black-white disparity to manifest." *Id. See also* Nina Martin & Renee Montagne, *Nothing Protects Black Women from Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017, 8:00 AM), https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth [https://perma.cc/3Z4C-FV8C] ("Weathering can have particularly serious repercussions in pregnancy and childbirth, the most physiologically complex time in a woman's life. Stress has been linked to one of the most common and consequential pregnancy complications, preterm birth. Black women are 49 percent more likely than whites to deliver prematurely (and, closely related, black infants are twice as likely as white babies to die before their first birthday). Here again, income and education aren't protective. The effects on the mother's health may also be far-reaching. Maternal age is an important risk factor for many severe pregnancy-related complications, as well as for chronic diseases that can affect pregnancy, like hypertension. 'As women get older, birth outcomes get worse,' [an expert] said. 'If that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s.'").

54. *See* Nina Martin, *Does a Larger Role for Midwives Mean Better Care?*, NPR (Feb. 22, 2018, 3:46 PM), https://www.npr.org/2018/02/22/587953272/does-a-larger-role-for-midwives-mean-better-care [https://perma.cc/VW8P-VYMZ].

than in 1850, fifteen years before the end of slavery.[55]

Thus, there are several reasons as to why the U.S. healthcare system puts Black women specifically at such a disadvantage. While midwives cannot fix institutional inequality in its entirety, they are an essential step to equalizing American maternity care.

C. ALABAMA

Alabama has one of the highest infant mortality rates in the country[56] and extremely low integration of midwives into the medical community. Prior to 2019, Alabama did not allow midwives to attend homebirths—instead homebirths were legal only if they were *unattended* by a professional; in 2020 Alabama revised this law to allow midwives at homebirths.[57] Because of the aftereffects of the original law, Alabama has significantly fewer midwives—as of January 2020, there were only fifteen licensed homebirth midwives in the state.[58] This correlation between lack of midwife access and high infant mortality has three likely causes: Alabama has denied midwives integration into the healthcare system, making it cost prohibitive; it is a state with many rural communities, which face unique healthcare challenges; and it has a large Black population that faces extremely high barriers to accessing medical care.

In the Alabama, 83% of midwives work with white patients, while only 17% of midwives work with people of color.[59] This disparity is likely because people of color are disproportionately impacted by poverty and midwifery care is cost prohibitive: seeing a midwife for prenatal appointments and delivery in Alabama usually costs between $3,500 and $6,400, with about 97% of clients paying out-of-pocket.[60] This is problematic because while communities of color face the highest barriers of access to midwives, they also have the highest risk of pregnancy complications, including maternal and infant deaths, likely because the barriers to adequate medical care and representation are so high.[61] Additionally,

---

55. *See* Villarosa, *supra* note 50 (calculating "11.3 per 1,000 black babies [die as infants], compared with 4.9 per 1,000 white babies").

56. *Infant Mortality Rates by State*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.ov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm [https://perma.cc/Q2Z9-7TYV] (last visited Aug. 25, 2022).

57. *See* Anna Claire Vollers, *Now Legal in Alabama, Homebirth Midwives Delivered Nearly 100 Babies in 2019*, AL.COM, (Jan. 17, 2020, 7:58 PM), https://www.al.com/news/2020/01/now-legal-in-alabama-homebirth-midwives-delivered-nearly-100-babies-in-2019.html [https://perma.cc/K8EJ-LG4V].

58. *Id.*

59. *Id.*

60. *See id.*; *see also* Martin, *supra* note 54 (noting that "greater use of midwives could reduce racial disparities in maternity care").

61. *See* Villarosa, *supra* note 50; *see also* Ericka Stallings, *The Article that Could Help Save Black Women's Lives*, OPRAH.COM, https://www.oprah.com/health_wellness/the-article-that-could-help-save-black-womens-lives#ixzz5VRnkBHiz [https://perma.cc/Z3NP-FSFH] (last visited Aug. 25, 2022) (discussing neighborhood health inequalities, specifically highlighting that predominantly Black neighborhoods have decreased access to medical specialists); *Alabama is the #10 State with the Most People Living in Maternal Health Care Deserts*, STACKER (Oct. 29, 2021), https://stacker.com/alabama/alabama-10-state-most-people-living-maternal-health-care-deserts [https://perma.cc/S8WS-XEMG] (noting that 13.2% of Alabama's Black population live in maternal healthcare deserts).

people of color face severe medical racism.[62] While increased use of midwives does not automatically correlate to a decrease in systematic racism or medical bias, midwives can often represent patients' interests better, leading to safer birthing environments.[63] For example, one study found that Black and Hispanic women on Medicaid whose care was overseen by midwives had fewer cesarean sections and more term births than risk-matched women did in obstetric prenatal care.[64] This indicates that these women are receiving higher standards of personalized care with midwives than with obstetricians. Thus, if communities of color in Alabama had greater access to midwives who were integrated into the healthcare system, their birth survival rates would likely improve because midwives offer a higher standard of care, especially prenatal care.[65] Therefore, people in Alabama not only face regulatory and financial barriers to obtaining midwives, but they also face dangers within hospitals due to racial bias, all of which contribute to Alabama having one of the highest infant mortality rates[66] and one of the worst maternal mortality rates in the country.[67]

Moreover, hospitals that serve mainly low-income and Black patients in rural areas are closing because they cannot financially break even without payouts from private insurance companies.[68] Hospitals make more money from private insurers than from Medicaid, Medicare, or the uninsured.[69] Alabama, Georgia, Texas, and Tennessee have all suffered from the shutdown of numerous hospitals that previously served mainly rural, low-income, and Black patients.[70] However, rural low-income communities, especially communities of color, are more likely to be uninsured due to high barriers to access.[71] These communities are also more likely to avoid hospitals in general due to mistrust or past trauma caused by substandard care experienced at these hospitals.[72] Not only does this perpetuate health disparities, but it also creates de facto racially segregated hospitals, such that those serving majority Black populations have more difficulty staying afloat

62. *See* STACKER, *supra* note 61 (detailing the history of medical racism in the United States and the distinct risks Black women face due to medical racism).

63. *See* Brigette Courtot, Ian Hill, Caitlin Cross-Barnet & Jenny Markell, *Midwifery and Birth Centers Under State Medicaid Programs: Current Limits to Beneficiary Access to a High-Value Model of Care*, 98 MILBANK Q. 1091, 1094 (2020).

64. *Id.*

65. *See* Martin, *supra* note 54 (quoting Saraswathi Vedam) ("In communities that are most at risk for adverse outcomes, increased access to midwives who can work as part of the health care system may improve both outcomes and the mothers' experience[.]"); *see infra* Section IV.D (explaining that midwives can offer higher standards of care to communities of color).

66. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, *supra* note 56.

67. *See* WORLD POPULATION REV., *supra* note 44.

68. *See* Judith Garber, *How Hospital Segregation Contributes to Racial Health Disparities*, LOWN INST. (Aug. 6, 2020), https://lowninstitute.org/how-hospital-segregation-contributes-to-racial-health-disparities/ [https://perma.cc/375E-YXQR]; Andy Miller, *A Rural Georgia Community Reels After Its Hospital Closes*, KAISER HEALTH NEWS (Dec. 10, 2021), https://khn.org/news/article/rural-hospital-closures-georgia/ [https://perma.cc/4WGD-8ZQS].

69. *See* Miller, *supra* note 68.

70. *See id.*

71. *See* Garber, *supra* note 68.

72. *See id.*

and maintaining the resources to provide high-quality care.[73] It also results in rural hospitals in the South, which mainly serve low-income Black patient populations, shutting down or being unable to meet the communities' needs.

As the next Parts showcase, midwives address America's (and Black patients') disparate birth outcomes in three ways: they help fill gaps in the quality of care across socioeconomic classes, offer solutions to improving care provided through Medicaid, and mitigate the stressors caused by institutional racism, which lead to worse birth outcomes.

II. LICENSING AND INTEGRATION OF MIDWIVES

State licensing restrictions bar midwives from reaching a larger range of pregnant people, especially Black women. To sufficiently serve all pregnant people, states must implement two fundamental changes: (1) states must license midwives to bolster midwives' credibility, which would better integrate them into the medical system; and (2) beyond granting licenses, states should loosen restrictions and oversight on practicing midwives so that they can serve people across socioeconomic classes. This Part ends by highlighting Pennsylvania and Washington State, both of which demonstrate different approaches to midwifery licensing. While Pennsylvania continues to implement licensing barriers to exclude midwives from their healthcare system, Washington exemplifies how states can successfully promote licensing and integrate midwives into their healthcare system.[74]

A. LICENSING DIFFICULTIES FOR MIDWIVES

All states have some form of laws and restrictions governing midwives, providing midwives with two main types of designated practice environments. The most common practice environment, which has been sanctioned by half of the states and is the advocated position of the American College of Nurse-Midwives, is referred to as "independent practice."[75] This form of practice is most available to nurse-midwives (midwives with nursing degrees).[76] Independent practice

73. *See id.*

74. *See Midwifery Integration State Scoring (MISS) System Report Card: Pennsylvania*, UNIV. OF B.C., https://www.birthplacelab.org/wp-content/uploads/2018/02/Pennsylvania.pdf [https://perma.cc/2PPN-QAKN] [hereinafter, *State Scoring: Pennsylvania*] (last visited Aug. 25, 2022); *Midwifery Integration State Scoring (MISS) System Report Card: Washington*, UNIV. OF B.C., https://www.birthplacelab.org/wp-content/uploads/2018/02/Washington.pdf [https://perma.cc/N5HM-B6SY] [hereinafter, *State Scoring: Washington*] (last visited Aug. 25, 2022).

75. *See* Position Statement, Am. Coll. of Nurse-Midwives, Independent Midwifery Practice (Feb. 2012) (available at http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000073/Independent-Midwifery-Practice-Feb-2012.pdf [https://perma.cc/LB6A-YN6F]).

76. Nurse-midwives are midwives who have received a nursing degree from an accredited program along with a midwifery degree. *See Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S.*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf [https://perma.cc/6XAK-XG2C] (last visited Aug. 25, 2022) (demonstrating that Certified Nurse-Midwives (CNMs) hold more authority than Certified Midwives (CMs) or Certified Professional Midwives (CPMs) in the United States; for

means that a nurse-midwife can use their medical judgment, equipped with prescriptive authority, without needing an overseeing doctor to approve the prescription.[77] Non-nurse midwives (midwives without nursing degrees) are more likely to be unable to practice independently and are more often restricted by the law.

Nineteen states require supervisory agreements for nurse-midwives to practice.[78] This means the nurse-midwife must enter into a formal agreement with a physician in order to obtain licensure, reimbursement, clinical privileging and hospital credentialing, and prescriptive authority.[79] In certain states, midwives may be unable to obtain hospital privileges if they cannot find a physician willing to enter the agreement.[80] Insurers may also deny reimbursement if the midwife does not have an agreement.[81] This formal contract requirement can create an economic disadvantage for midwives—without a contract, they may not be considered professionals and therefore are unable to open their own practices as Professional Limited Liability Corporations (PLLC); without PLLC status, insurance is less likely to cover midwives, leaving patients to pay out-of-pocket.[82] These contracts can also restrict the number of midwives allowed to practice with a specific physician, limiting the number of midwives able to practice in a specific area.[83] Moreover, physicians may be unwilling to enter these collaborations with midwives because midwives are their market competitors[84] and because if the midwife is sued, the overseeing physician may face vicarious liability.[85]

---

example, while CNMs have some form of prescriptive authority in all fifty states, CMs only have prescriptive authority in New York, Rhode Island, and Maine, and CPMs have no prescriptive authority).

77. *See* Position Statement, *supra* note 75; *see also* Position Statement, Am. Coll. of Nurse-Midwives, Collaborative Agreements Between Physicians and Certified Nurse-Midwives and Certified Midwives (Dec. 2011), http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOADFILENAME/000000000057/Collaborative%20Agreement%20between%20Physicians%20and%20CNMs.CMs%20Dec%20%202011.pdf [https://perma.cc/9LZ7-FWHC] (arguing that collaborative agreements between midwives and physicians are too restrictive, and that midwives should be able to practice independently with prescriptive authority); Laura A. Stokowski, *APRN Prescribing Law: A State-By-State Summary*, MEDSCAPE (Jan. 4, 2018), https://www.medscape.com/viewarticle/440315 ("Independent prescribing (also called 'prescriptive authority') is the ability of advanced practice registered nurses (APRNs) to prescribe, without limitation, legend (prescription) and controlled drugs, devices, adjunct health/medical services, durable medical goods, and other equipment and supplies.").

78. *See States that Allow CNMs to Practice and Prescribe Independently vs Those that Require a Collaborative Agreement*, MIDWIFE SCHOOLING, https://www.midwifeschooling.com/independent-practice-and-collaborative-agreement-states/ [https://perma.cc/4CDP-4AEU] (last visited Aug. 25, 2022); *see also How Does the Role of Nurse-Midwives Change from State to State?*, NURSING@GEORGETOWN (Feb. 5, 2019), https://online.nursing.georgetown.edu/blog/scope-of-practice-for-midwives/ [https://perma.cc/48H5-UZJ2] (map showing which states require supervisory or collaborative agreements).

79. *See* Position Statement, *supra* note 77.

80. *See* Deborah Walker, Barbara Lannen & Debra Rossie, *Midwifery Practice and Education: Current Challenges and Opportunities*, 19 ONLINE J. OF ISSUES IN NURSING, no. 2, May 2014, at 4.

81. *Id.* at 2.

82. *See id.*

83. *Id.*

84. *See* discussion *infra* Section III.B for elaboration on collaborations and market competition between obstetricians and midwives.

85. *See* Walker et al., *supra* note 80.

In states that require supervisory agreements, midwives also struggle to gain prescriptive authority, which they need to best serve their patients. While in some states, midwives may be technically allowed to prescribe medication to patients, supervisory agreement laws have now been interpreted to strip midwives of prescriptive authority, demanding that midwives rely on doctors with whom they signed the agreement in order to write prescriptions.[86] This results in both patient and pharmacy confusion as to the primary care provider and undermines the midwife's authority.[87]

Therefore, for midwives to practice more broadly in the United States, states must first ensure that licenses actually give midwives authority to practice freely. This would include states eliminating collaboration agreement requirements, offering hospital privileges to nurse- and non-nurse midwives, and giving nurse- and non-nurse midwives greater prescriptive authority.

B. PENNSYLVANIA

Pennsylvania's failure to integrate midwifery into the medical system demonstrates why midwives must be licensed and have freedom of practice. Pennsylvania hinders nurse-midwives by insisting they have written collaborative agreements with obstetricians or gynecologists with hospital privileges.[88] These agreements formally limit nurse-midwives' practice to exactly what is written in the agreement.[89] Pennsylvania's State Board of Medicine dictates the limitations within these agreements, yet nonphysicians possess almost no representation on the Board.[90] Without a seat at the table during discussions about limitations on collaborative agreements, nurse-midwives lack an avenue to represent their own particular interests to the Board. This consequently strips nurse-midwives of autonomy. These restrictions make midwifery an unsafe practice in Pennsylvania because the nurse-midwife cannot access medicine to adequately care for the patient should anything go wrong during the pregnancy or birthing process.

Furthermore, Pennsylvania's legislation is silent on regulating non-nurse midwives.[91] These midwives therefore practice without licenses and are unregulated by the state, resulting in midwifery detached from the Pennsylvania healthcare system.[92] This lack of regulation over non-nurse midwifery licensing generates confusion; many who work within the state are unsure if the practice is legal or not.[93] Consequently, "[s]ome believe that it is 'alegal'—neither legal nor illegal—to have a home birth in Pennsylvania. . . . Others believe that it is legal to practice

86. *Id.* ("For example, in Michigan prescribing is the only midwife practice area requiring physician supervision or collaboration. However, the legal interpretation of this law has evolved into the opinion that if prescribing is supervised then perforce practice must be also.").

87. *See id.*

88. *See* Levinson, *supra* note 9, at 151.

89. *Id.*

90. *Id.*

91. *See id.* at 155.

92. *See id.* at 140.

93. *Id.* at 155.

as a non-nurse midwife in Pennsylvania without a license."[94] This not only leaves non-nurse midwives without formal training overseen by the state, but forces midwives to live in a state of uncertainty, unsure if Pennsylvania will one day prosecute them for a potentially illegal act.[95] It also opens up Pennsylvanian midwives to financial ruin from civil lawsuits because patients can file tort claims for injuries attributable to the midwife—most non-nurse midwives carry little or no malpractice insurance and are often low-income themselves.[96] Midwives can even be held criminally accountable, prosecuted when a child dies during birth.[97] Altogether, this creates an unstable environment for practice. This results in Pennsylvania having both a higher use of midwives than the national average and a higher infant mortality rate.[98]

Therefore, Pennsylvania's limitations on nurse-midwives and lack of recognition of non-nurse midwifery as a profession endangers both patients and midwives. While fewer restrictions on midwives would better integrate them into the healthcare system, Pennsylvania exemplifies why midwives must at least be recognized by the state as independent medical providers. Essentially, midwives need fewer state-created barriers to access their patients, including more resources and autonomy, in addition to receiving state recognition for their position within the healthcare system. This is a contributing factor to why Pennsylvania's neonatal mortality rate is higher than the national average.

C. WASHINGTON

Washington State utilizes midwives at the same statistical rate as Pennsylvania,[99] but has significantly better outcomes. This can be explained by the two states' vastly different approaches to midwifery integration and freedom of practice within their respective healthcare systems.

---

94. *Id.*

95. *See id.* at 156.

96. *Id.*

97. *See id.* at 157–58; *see also* Dianne Anderson Kammerer, U.S. Antitrust Law and the Control of Nurse-Midwifery: 1975 to the Present 34 (May 10, 1992) (Ph.D. dissertation, George Washington University) (on file with author) (explaining that "[a]s early as 1912, it was stated that 'the medical profession would never be forced by law to respond to the call of the midwife in trouble['']"); Tiffany Thomas, *Is Home Birth Legal in All States?*, ROMPER (May 25, 2017), https://www.romper.com/p/is-home-birth-legal-in-all-states-the-right-to-choose-applies-here-too-59624 [https://perma.cc/DH5B-CXL8] ("For starters, midwives practicing without a license weren't as likely to call on hospitals for help in an emergency, according to a *TIME* report. And operating without oversight from a licensing authority meant no clear educational standard for practitioners or a path for ongoing professional development. . . . While some in the medical community have blamed certified professional midwives for [dangerous homebirth outcomes], the problem might have more to do with the dangers of working in isolation.").

98. *See State Scoring: Pennsylvania*, *supra* note 74 (reporting that 4.8 out of every 1000 infants in Pennsylvania die, in contrast to 4 out of 1000 nationally).

99. *Compare id.* (reporting that 13.7% of births in Pennsylvania are attended by midwives), *with State Scoring: Washington*, *supra* note 74 (reporting that 13.4% of births in Washington are attended by midwives).

Washington touts both the highest midwife integration in the United States and the best birth outcomes in the country.[100] The state's liberal view of midwives permits non-nurse midwives to operate as independent practitioners instead of being overseen by a physician, additionally equipping midwives with some prescribing authority and the ability to act as a primary care provider during pregnancy, as well as the authority to aid parents for the first six weeks of a newborn's life.[101] Through integration into Washington's healthcare system, nurse and non-nurse midwives are able to supervise nurses, call an obstetrician for consultation, oversee labor and birth, and gain access to medical technology that provides the best birth outcomes.[102] Non-nurse midwives do not have hospital privileges, nor can they prescribe drugs or provide primary care outside of pregnancy care. They can, however, draw blood for routine testing, perform pap smears, and authorize the administration of certain types of medications during and after birth, particularly intravenous fluids, antibiotics, drugs to control bleeding, and newborn immunizations, all of which are essential preventative healthcare for new mothers and babies.[103] Non-nurse midwives are also able to transfer patients to hospitals if homebirths result in complications, making them a realistic option for people with both low-risk and high-risk pregnancies.

Although Washington gives licensed non-nurse midwives the highest level of independent authority over maternity care, it has some of the strictest requirements in the country for non-nurse midwives to obtain these licenses. While some states permit midwives to practice with almost no background education (or in Pennsylvania's case, stay silent on the issue), Washington demands midwives attend a three-year program with the Midwifery Education Accreditation Council, where midwives attend at least one hundred births during training.[104] They then must pass several state exams to receive qualification.[105] While Pennsylvania struggles to integrate midwives into their healthcare system, Washington has given midwives the tools to perform successful births through state-led support and quality standardization of the profession. This results in two states with the same statistical usage of midwives, but one with far greater success.

III. ECONOMIC BARRIERS

Economic barriers to midwifery integration, specifically hospital breaches of antitrust laws, exclude midwives from competing against obstetricians for patients. These barriers restrict midwives from aiding patients who lack the

100. *See State Scoring: Washington*, *supra* note 74.

101. *See* Sandi Doughton, *Trying to Clear Up the Confusion About Midwives in Washington. Who Are They, and What Do They Do?*, SEATTLE TIMES (Mar. 15, 2020, 7:00 AM), https://www.seattletimes.com/pacific-nw-magazine/trying-to-clear-up-the-confusion-about-midwives-in-washington-who-are-they-and-what-do-they-do/.

102. *Id.*

103. *See id.*

104. *Id.*

105. *Id.*

finances to pay out-of-pocket, resulting in overall worse birth outcomes. This Part discusses civil suits and FTC investigations against hospitals, insurers, and doctors. These suits and investigations find traction under the Sherman Act, which forbids conspiracies that actively prevent midwives from practicing and in turn creates a monopoly of obstetricians.

A. OVERVIEW OF ECONOMIC COMPETITION BETWEEN MIDWIVES AND OBSTETRICIANS

Hospitals in the United States have threatened midwives by monopolizing obstetrics. Prior to 1930, birth was not considered a medical event, with less than 5% of women giving birth in hospitals in the year 1900; instead, almost all births were overseen by midwives at home, where mortality rates were lower due to avoidance of disease exposure in hospitals.[106] However, hospitals began emphasizing obstetrics over midwifery care, and by 1935, midwives only oversaw 5% of births, though 54% of births involving Black mothers were assisted by midwives.[107] This shift to midwives serving mainly Black patients stemmed from Southern Jim Crow laws.[108] Southern white doctors often refused care to Black women, leading to 80% of America's midwife population residing in Southern states by the 1930s because midwives continued to be integral caregivers to Southern Black mothers who were denied hospital access.[109] Additionally, Southern Black women in particularly rural and low-income communities often chose not to give birth in hospitals that did admit Black women because these hospitals were "unfamiliar, far away, and costlier than midwife care."[110] Thus, most Black women in Southern states, especially Alabama, relied on "granny midwives" throughout the first half of the twentieth century.[111] By 1960, almost 100% of deliveries took place in hospitals, in part because third-party insurers began to cover hospital births; however, these insurers refused to cover at-home births with midwives, which made midwives the more expensive option for mothers.[112] The rise in hospital births was also due to the growth of obstetrics as a

106. *See* Brown, *supra* note 6, at 3; *see also* Phyllis L. Brodsky, *Where Have All the Midwives Gone?*, 17 J. PERINATAL EDUC. 48, 49–50 (2008) (describing asepsis maternal deaths in hospitals due to unsanitary medical practices).

107. *See* Brown, *supra* note 6, at 3–4; *see also* Stacey A. Tovino, *American Midwifery Litigation and State Legislative Preferences for Physician-Controlled Childbirth*, 11 CARDOZO WOMEN'S L.J. 61, 68 n.63 (2004) ("Indeed, in 1935, although only five percent of white pregnant women were attended by midwives, fifty-four percent of black pregnant women were attended by midwives. By 1953, both races' use of midwives dropped: only three percent of white women, and twenty percent of black women, were attended by midwives during their deliveries.").

108. STACKER, *supra* note 61 ("Under Jim Crow laws, Black parents couldn't access white hospitals, and Black midwives played a crucial role in overseeing births.").

109. *See* Tovino, *supra* note 107, at 71.

110. *Id.*

111. *See In Honor of Black History Month We Spotlight the Granny Midwives and Their Legacy*, ALAMEDA HEALTH SYS. (Feb. 9, 2021), https://www.alamedahealthsystem.org/honoring-the-granny-midwives-and-their-legacy/ [https://perma.cc/VF44-XKMJ] ("The granny midwives were well respected Black women from the South who provided care to poor and rural women during pregnancy and labor at a time when hospitals were not accessible to them. They were family counselors, breastfeeding consultants, postpartum doulas, nutritionists, and advocates.").

112. *See* Kammerer, *supra* note 97, at 35.

practice and an increase in funding provided to hospitals to expand and take on greater numbers of patients.[113]

As obstetricians grew in popularity, midwives sought higher education within hospitals, but obstetricians refused to train them in an effort to eradicate the practice and bring more income to hospitals.[114] This stands in contrast with Europe's development of modern midwifery. As early twentieth-century technology paved the way for the medicalization of birth, Europeans worked to integrate midwives into these systems, offering accessible education and creating a dual system where midwives attended births, while obstetricians and physicians handled complex cases.[115] European healthcare systems encouraged collaboration between midwives and obstetricians because there was, and still is, no market competition between them.[116] This resulted in more frequent use of midwives in countries with universal healthcare, and likely contributes to the safer and more cost-effective birth outcomes seen today.[117]

The United States sets itself apart from European countries because it lacks universal healthcare,[118] creating a system where hospitals financially compete with midwives for business. Thus, American obstetricians continue to advocate against homebirths in an effort to keep midwives out of the birthing room.[119] And physicians may refuse to enter into collaborative agreements with midwives in states that require such agreements for midwives to practice because doing so would potentially give pregnant people—effectively consumers in the American healthcare system—access to midwives, which would shrink the obstetricians' clientele.

---

113. *See id*. at 35–36.

114. *See* Brodsky, *supra* note 106, at 49; *see also* Kammerer, *supra* note 97, at 21 ("The first formal American education program for nurse-midwives, the Clinic and School of the Association for the Promotion and Standardization of Midwifery (the Lobenstine Midwifery School) was established in New York City in 1932. The Lobenstine Midwifery School and the Maternity Center Association (MCA) merged in 1934. Philanthropists and foundations provided initial funding for MCA. In 1941, the Tuskegee Nurse-Midwifery School was established with the help of graduates from MCA. The school helped to educate black nurses in midwifery. It closed in six years[.]").

115. *See* Brodsky, *supra* note 106, at 49.

116. *See id.* ("Schools for midwifery education were established in European cities, and European health care created a dual system by which midwives continued to attend normal births while physicians handled complications. This did not happen in the United States. American physicians fought hard against midwifery education, in spite of midwives wanting an education, which public-health reformers supported.").

117. *See* Roosa Tikkanen, Munira Z. Gunja, Molly FitzGerald & Laurie Zephyrin, *Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries*, COMMONWEALTH FUND (Nov. 18, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries [https://perma.cc/828V-NYFW] (noting that universal maternity care coverage, including both midwife and obstetrician services, is the norm in most high-income countries besides the United States).

118. *See* Dominic Montagu, *The Provision of Private Healthcare Services in European Countries: Recent Data and Lessons for Universal Health Coverage in Other Settings*, FRONTIERS IN PUB. HEALTH, Mar. 2021, at 1 (noting that every country in Europe has some form of universal healthcare).

119. *See* Brodsky, *supra* note 106.

Unfortunately, this anti-midwife approach has resulted in a remarkably worse birth environment, where midwives practice in poor or rural areas because they cannot gain hospital access. Moreover, in the years following the rise of obstetricians, childbirth has become a highly medicalized procedure, but not necessarily one that serves patients. For example, giving birth in the supine position is for the convenience of doctors: "epidurals combined with pushing in a supine position are associated with an increased risk of episiotomies, vacuum and forceps-assisted deliveries, fetal heart rate abnormalities, second-degree tears, and blood loss."[120] Studies indicate that the best position for birthing is squatting, a position rarely used in hospitals due to inconvenience.[121]

Additionally, without midwives, people are often less informed of their birthing options and types of medical intervention, leading to more situations in which doctors use overly aggressive practices.[122] This is particularly apparent in U.S. reliance on unnecessary cesareans; the World Health Organization recommends cesarean rates stay below 15% of births because a higher rate is "not associated with better maternal or neonatal mortality rates."[123] However, the United States touts a cesarean rate of 32.2%, half of which researchers estimate are performed unnecessarily.[124] This indicates that doctors overuse cesareans when other less invasive measures may actually lead to better results. Despite evidence that over-medicalization results in harm to patients and children, the American Medical Association is still pushing for heavier regulations on midwives by demanding more physician oversight and promoting legislation that all births take place in hospitals.[125] Much of this tension between midwives and physicians is rooted in financial incentives.

Midwives do not work for or earn as much money for hospitals as do obstetricians, which disincentivizes hospitals from supporting midwifery. As a result, hospitals have put restrictions on nurse and non-nurse midwives' access to medical practice for anticompetitive reasons that midwifery advocates have said—and this Note agrees—amount to breaches of Section 1 of the Sherman Antitrust Act ("Sherman Act").[126] Section 1 prohibits conspiracies or contracts that are in restraint of trade; hospitals and physicians potentially violate this section when they conspire to exclude midwives from practice.[127] This concerted effort to stop the practice of midwives results in the removal of an entire type of healthcare

120. Brown, *supra* note 6, at 5.

121. *Id*. at 4.

122. *See* Brodsky, *supra* note 106, at 49–50.

123. Brown, *supra* note 6, at 9.

124. *Id*. at 9–10.

125. *See* Brodsky, *supra* note 106, at 50; *see also* Brown, *supra* note 6, at 21. This type of heavy regulation is continuing. For example, "In 2014, midwives attended only eight percent of all hospital births due to more heavy regulation and influence by the [American College of Obstetricians and Gynecologists] lobby." *Id*.

126. *See* LUCINDA E. JESSON & STACY A. TOVINO, COMPLEMENTARY AND ALTERNATIVE MEDICINE AND THE LAW 228 (2010); *see also* Sherman Antitrust Act, 15 U.S.C. § 1.

127. *See* Caitlin Slessor, *The Right to Choose in Childbirth: Regulation of Midwifery in Iowa*, 8 J. GENDER, RACE & JUST. 507, 520 (2004).

provider for mothers, which, as discussed previously, leads to more dangerous birthing scenarios.

B. CIVIL SUITS UNDER THE SHERMAN ACT AND GOVERNMENT INVESTIGATIONS

Physicians' and hospitals' efforts to stop midwives from practicing, combined with a lack of information and options for pregnant people, lead to antitrust issues. This can breach a competitive capitalist market's basic economics tenets, which are protected under the Sherman Act.[128]

A capitalist marketplace demands that participants compete with each other because this competition gives consumers a "dollar vote." Consumers essentially control the marketplace, indicating which products are in demand by spending, and thus "voting," on which products are the most popular.[129] Based on these "votes," producers track spending patterns and change their products to better align with what consumers want. Therefore, a competitive marketplace constantly signals which products are in demand and market competitors act upon these signals to change their products to better serve the consumers who "voted" for these changes.[130] This competition encourages competitors to create better and cheaper versions of high-selling products, optimizing products for consumers. To deny consumers their dollar vote by purposely pushing out competitors and monopolizing the market can amount to a violation of the Sherman Act.[131]

This logic applies within the market of childbirth.[132] Because of hospitals' historical campaign against midwives and their refusal to integrate them into institutionalized healthcare, midwives have been systematically pushed out of the competitive market. This can violate antitrust laws because it deprives consumers of the right to choose between obstetricians and midwives, which creates a monopoly of obstetricians and hinders a successful competitive market. Hospitals are thus enabled to set their own market prices, depriving consumers of a dollar vote, and ultimately failing to incentivize hospitals to provide parents with better and cheaper childbirth options.[133] Moreover, restrictions on midwives, such as

---

128. *See* 15 U.S.C. § 1.

129. Jonathan B. Pitt, Antitrust Law Class Lecture 1 at Georgetown University Law Center (Jan. 25, 2021).

130. *See id.*

131. *See id.* These actions would create an antitrust violation if other elements of monopolization (Section 2 of the Sherman Act) or horizontal collusion (Section 1 of the Sherman Act) are met, which would depend on the market in which the antitrust violations are operating.

132. *See* JESSON & TOVINO, *supra* note 126.

133. Saraswathi Vedam, Kathrin Stoll, Marian MacDorman, Eugene Declercq, Renee Cramer, Melissa Cheyney, Timothy Fisher, Emma Butt, Y. Tony Yang & Holly Powell Kennedy, *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, PLOS ONE, Feb. 21, 2018, at 3, 12 ("[C]ollaboration among health professionals can improve safety and quality, particularly when care is transferred from low to high resource settings. For example, when a woman plans to give birth in a community setting (home or birth center) she benefits when her midwife can facilitate access to specialized hospital personnel, equipment, or medications when necessary. The ability of midwives to function autonomously to their full scope of practice in community settings, in collaboration with other members of the health system, can enhance cost-effectiveness of maternity care." (footnotes omitted)).

requiring them to have overseeing physicians in the birthing room or collaborative agreements, are anticompetitive because they force midwives to rely on their market competitors.[134] These physicians have no incentive to help midwives practice because midwives can provide the same service at a significantly lower cost; if physicians were to help midwives, they would be putting themselves out of work.[135] Therefore, these restrictions make midwives beholden to doctors' demands instead of creating an environment where the consumer has realistic options, especially in rural areas where there is a higher demand for midwives but fewer doctors with whom midwives can work.[136] These anticompetitive actions, in conjunction with denying midwives hospital admitting privileges purely because they are physicians' and hospitals' market competitors, can amount to violations of Section 1 of the Sherman Act, as physicians and hospitals actively conspire to exclude midwives from their practice.[137]

In the 1980s and 1990s, as the FTC began investigating antitrust claims made by midwives against hospitals,[138] civil suits under the Sherman Act between midwives and hospitals also gained prevalence. However, these investigations and suits declined in popularity by the early aughts.[139] This Note therefore covers some of this background, as this antitrust argument could potentially be revived today to help midwives expand their practices.

1. *Sweeney v. Athens Regional Medical Center*

Sweeney v. Athens Regional Medical Center,[140] a 1989 civil case where a midwife defeated summary judgment on her claims of Sherman Act violations, provides a notable example of this argument's legal viability. Sweeney stated that her hospital conspired with doctors to eradicate her "Family Birth" business by disallowing her or her students from making contact with patients and creating a written policy that denied staff privileges to any obstetrician who participated in, or provided backup for, homebirths.[141] Obstetricians at two hospitals also wrote a joint letter to the hospitals' administrators advocating for the end of Sweeney's

134. *See* Slessor, *supra* note 127, at 528.

135. *See id.*

136. *See id.*

137. *See id.* at 520.

138. *See* Kammerer, *supra* note 97, at 8–9 (noting that prior to 1975, medicine was considered "outside the purview of antitrust laws" because it did not involve trade or commerce). In two cases in the 1970s, *Goldfarb v. Va. State Bar* and *Nat'l Soc'y of Pro. Eng'rs v. United States*, the Supreme Court rejected the "learned-profession exemption" that had previously protected doctors from antitrust lawsuits. *Id.* Because of these cases, midwives were able to sue hospitals in the early 1980s and 1990s.

139. *See* FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 39, 41, 116 (2022), https://www.ftc.gov/system/files/ftc_gov/pdf/2022.04.08%20Overview%20Healthcare%20%28final%29.pdf [https://perma.cc/PNP6-JKCK]. Although there is no clear explanation for why these suits ended, it is likely that hospitals were put on notice not to openly inform midwives that they were avoiding competition, relying instead on rhetoric emphasizing the dangers of midwives to box them out. Without explicit anticompetitive statements from hospitals, it became difficult for midwives to bring antitrust cases.

140. 709 F. Supp. 1563 (M.D. Ga. 1989).

141. *Id.* at 1568.

practice; eventually physicians at one of the hospitals agreed to unite and deny Sweeney patient access.[142] The physicians "formalized this agreement in a letter to the nursing director of that hospital."[143]

The court analyzed the Sherman Act claims of this case, stating that "[t]o invoke the jurisdiction of the Sherman Act, . . . a plaintiff [must] show (1) that the local activity has a (2) substantial affect on (3) interstate commerce."[144] The court emphasized that "to satisfy the jurisdiction requirement, the defendants' activities in aggregate must have a substantial effect on interstate commerce or markets."[145] Additionally, to prove conspiracy under the Sherman Act, the court explained that "the plaintiff must produce evidence that reasonably tends to prove that defendants 'had a conscious commitment to a common scheme designed to achieve an unlawful objective'" and that "the defendants were acting in accord with one another—mutually assenting."[146]

Sweeney's case moved forward on this claim. The court relied on Eleventh Circuit precedent that a plaintiff "need not show that the alleged unlawful activity had an effect on interstate commerce."[147] Even so, based in part on how much money the doctors made from out-of-state entities, the court found that defendants' actions did have a "substantial or not insubstantial" effect on interstate commerce.[148] Moreover, the court found that Sweeney produced "sufficient evidence to raise a factual question as to whether the Defendant doctors were involved in a conspiracy to unreasonably restrain her teaching duties and home-birth business."[149] This evidence included the letter the obstetricians wrote to the hospital administrators, meeting minutes demonstrating the hospital threatened to expel physicians who aided out-of-hospital deliveries, deposition testimony that supported Sweeney's theory of a conspiracy, and doctors' refusal to let Sweeney or her students care for their patients at the hospital.[150] Although the case was later settled, it demonstrates that midwives can leverage this kind of antitrust argument to potentially achieve success against hospitals today.[151]

2. *Nurse Midwifery Associates v. Hibbett*

Nurse Midwifery Associates v. Hibbett[152] is a seminal case in nurse-midwifery and antitrust law. Two nurse-midwives, their affiliated obstetrician, and three

142. Joseph Mark Saponaro, *Determining the Immunity Measuring Stick: The Impact of the Health Care Quality Improvement Act and Antitrust Laws on Immunity Aspects of Granting Privileges to Physician Assistants*, 47 CLEV. STATE L. REV. 115, 130 (1999).

143. *Id.*

144. *Sweeney*, 709 F. Supp. at 1570.

145. Saponaro, *supra* note 142, at 131.

146. *Id.* (quoting *Sweeney*, 709 F. Supp. at 1572).

147. *Sweeney*, 709 F. Supp. at 1570 (citing Shahawy v. Harrison, 778 F.2d 636, 641 (11th Cir. 1985)).

148. *See id.* at 1570–71.

149. *Id.* at 1572.

150. *Id.* at 1576.

151. *See* Slessor, *supra* note 127, at 521.

152. 918 F.2d 605 (6th Cir. 1990).

clients sued three Nashville hospitals, members of the medical staff from two hospitals, a practicing obstetrician in Nashville, and a physician-controlled insurance company.[153] The nurse-midwives alleged that the defendants had violated Section 1 of the Sherman Act by engaging in several conspiracies in restraint of trade.[154] The lower court allowed only one such claim of conspiracy to move forward, granting summary judgment in favor of the defendants on all other claims, even after observing that the nurse-midwives had applied to three hospitals and obstetricians had voted to bar the midwives from the hospitals.[155] The obstetricians had not inquired into the practice of the midwives and were not "interested in the manner in which the nurse-midwives practiced during interviews with the midwives nor when the doctors reviewed the midwives' applications for hospital admitting privileges."[156] These obstetricians then "threaten[ed] to adopt new policies that precluded standard midwifery practices," "barred the midwives from practicing in one of the three hospitals" to which they applied for privileges, and "refused to produce a copy of the committee's report" as to why the midwives were rejected.[157] In court, the nurse-midwives provided evidence of meetings between obstetricians discussing ways to bar them from practice.[158] They also provided evidence that the obstetrician who did work with the midwives had his malpractice insurance dropped due to his affiliation with midwifery.[159]

The Sixth Circuit reversed the lower court's grant of summary judgment in favor of the defendants.[160] The circuit court reasoned that under Section 1 of the Sherman Act, officers or employees of a corporation were "shielded from alleged conspiracy with agents," but that the obstetricians in this case were not agents of the hospital when they recommended against hospital privileges for the midwives.[161] The court explained that "a corporation cannot conspire with its [own] agents or employees," but noted that "such a conspiracy can exist when the employee has an independent personal stake in achieving the object of the conspiracy."[162] Thus, when recommending against hospital privileges for the midwives, the obstetricians acted as "more than 'agents' of the hospital for antitrust purposes."[163]

3. FTC Investigations

The FTC has made a series of investigations or statements opposing anticompetitive actions taken by hospitals, insurance carriers, or physicians against

153. *Id*. at 607.
154. *Id.*
155. *See id*. at 607–11.
156. *See* Brown, *supra* note 6, at 19.
157. *Id*. at 20.
158. *Id.*
159. *Id.*
160. *Hibbett*, 918 F.2d at 617.
161. Brown, *supra* note 6, at 20–21; *see also Hibbett*, 918 F.2d at 613–15.
162. *Hibbett*, 918 F.2d at 613.
163. *Id*. at 612.

midwives.[164] The following investigation showcases this trend. In 1983, Rebecca Almand, a nurse-midwife, was initially approved but then denied hospital privileges by Memorial Medical Center in Savannah, Georgia.[165] The FTC's complaint explicitly noted that members of the hospital's obstetrical services were "actual or potential competitors of nurse-midwives."[166] Two representatives of the hospital's obstetrics and gynecology department said Almand would "create an 'economic problem' for obstetricians,"[167] and the FTC alleged that the primary purpose of the hospital's rejection was "to restrain trade unreasonably and hinder competition in the provision of health care services in the Savannah metropolitan area, and to deprive consumers of the benefits of competition."[168] Therefore, the FTC concluded that Almand had been impermissibly denied hospital privileges for anticompetitive reasons.[169]

C. MOVING FORWARD WITH ANTITRUST CLAIMS

Utilizing private lawsuits or relying on the FTC to protect midwifery businesses against anticompetitive practices has some successful precedent, indicating that midwives could revitalize these suits today if they are unable to obtain hospital privileges or insurance. Additionally, there is a recent trend of states attempting to improve their birthing outcomes through legislation promoting

164. *See, e.g.*, FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS 42 (2019), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_june_2019.pdf [https://perma.cc/XSG7-5Z54] (summarizing final order against State Volunteer Mutual Insurance Company, Inc., C-3115, 102 F.T.C. 1232: "The complaint charged that a Tennessee physician-owned insurance company providing malpractice insurance terminated the insurance of a physician because he had agreed to serve as a back-up physician to certified nurse-midwives who were in independent practice. The order prohibits the insurance company from unreasonably discriminating against physicians who work with independent nurse midwives."); Sandra Evans Teeley, *New Plan Offered to Allow Midwives in D.C. Hospitals*, WASH. POST (June 28, 1983), https://www.washingtonpost.com/archive/local/1983/06/28/new-plan-offered-to-allow-midwives-in-dc-hospitals/c489f2ce-1221-478c-9b72-832679483372/ (detailing the FTC's interest in a plan proposed by a Washington, D.C. City Council member that would ensure local midwives have access to hospital facilities: "Federal Trade Commissioner Patricia P. Bailey, meanwhile, submitted comments to [the city council member], saying that competition between physicians and nonphysician practitioners benefits consumers by giving them alternative choices on treatment and by lowering the overall cost of health care"); FTC, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES 7 n.24 (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [https://perma.cc/CQJ9-GNJ2] (listing comments and amicus curiae briefs submitted by the FTC supporting midwives); Michael de Courcy Hinds, *Midwives Seek Delivery from Discrimination*, N.Y. TIMES, Aug. 7, 1983, at E9 (reporting on the FTC's preliminary consent order against an insurance company that canceled the malpractice insurance of an obstetrician working with independent nurse-midwives).

165. *See* Med. Staff of Mem'l Med. Ctr., 110 F.T.C. 541, 543–44 (1988).

166. *Id.* at 543.

167. *Id.* at 544.

168. *Id.* at 545.

169. *Id.* at 541 (prohibiting the staff of Memorial Medical Center from "denying, restricting, or recommending denial or restriction of hospital privileges for any nurse-midwife, unless the staff has a reasonable basis for believing that such restriction serves the interest of the hospital in providing health care services" and "refusing to deal with or coercing the hospital or any person, organization, or institution, if the purpose or effect is to restrict the practice of nurse-midwifery").

midwifery.[170] This recent legislation, combined with antitrust precedent, demonstrates that states are more seriously considering the rights of midwives and could be inclined to protect them from hospitals or doctors impeding their businesses.

Moreover, states have financial incentives to protect midwives because they decrease overall maternity costs. Childbirth is the leading reason for hospitalization among women of reproductive age, putting a huge strain on Medicaid programs.[171] Midwives provide significantly cheaper maternity care than obstetricians and would therefore lower the maternity cost to Medicaid, giving states a financial incentive to prosecute institutions that attack midwifery.[172] Therefore, because states are currently seeking to improve birthing outcomes and lower birthing costs, an antitrust argument under the Sherman Act could be revitalized to protect the practice of midwifery.

IV. SOLUTIONS

This Part uses the information provided in the preceding Parts to advance public policy arguments that address America's birthing outcomes. All these arguments center around the specific crisis of Black people's birth outcomes in Southern states.[173]

Section A first discusses universal healthcare, which would solve many of the economic issues caused by the costly U.S. for-profit healthcare system; Section B suggests covering midwives under Medicaid, which would lower the cost of birth for states and create greater access to midwives; Section C highlights the need to train more midwives in Southern states; and Section D proffers that building more birth centers overseen by midwives would create more avenues for low-income Southern Black people to access prenatal, birth, and postnatal care.[174]

---

170. *See* discussion *infra* Section IV.B; *see also* Aallyah Wright, *Rural Midwives Fill Gap as Hospitals Cut Childbirth Services*, CT MIRROR (Dec. 11, 2021), https://ctmirror.org/2021/12/11/rural-midwives-fill-gap-as-hospitals-cut-childbirth-services/ [https://perma.cc/YP7G-6G5K] (noting that in 2021, eight states—Arizona, Arkansas, California, Colorado, Connecticut, Louisiana, Nevada, and Rhode Island—passed legislation to advance birthing outcomes through midwifery).

171. *See infra* Section IV.B.

172. *See infra* Section IV.B.

173. This Note acknowledges that midwives alone cannot *solve* the issue of institutional and systemic racism. This Note therefore advocates not only for midwifery care, but for greater institutional change regarding issues such as equal pay initiatives and higher quality public schools.

174. This Note does not address in detail, however it should be noted, that practicing midwives are mainly white women who oversee the births of white women. *See generally* Jyesha Wren Serbin & Elizabeth Donnelly, *The Impact of Racism and Midwifery's Lack of Racial Diversity: A Literature Review*, 61 J. MIDWIFERY & WOMEN'S HEALTH 694 (2016) (noting that 90% of nurse-midwives are white). Midwifery would be a more inclusive practice if the midwives practicing reflected the diverse populations they serve. For this to be achieved, medical education and licensing need to become more accessible to more people of different races, genders, and socioeconomic classes. Additionally, although this Note does not focus on doulas, covering doulas via Medicaid could also alleviate the over-medicalization of Black women's births by reducing stress levels and providing emotional support to new parents, in turn helping to manage pregnancy-related issues that arise in Black patients, such as preeclampsia. Doulas and midwives together could also form a cheaper team than a single obstetrician, and offer better postnatal care for up to a year after the birth because they are more involved in the day-to-day life of the parent. *See* Villarosa, *supra* note 50.

Although this Part focuses on Black people in the South—who have the highest barriers to access—making these changes in all states would create safer birth outcomes across racial and socioeconomic lines.

A. UNIVERSAL HEALTHCARE

Hospitals are unique in the United States because, unlike in countries with universal healthcare systems, hospitals are considered businesses. Like businesses, hospitals must prioritize their bottom lines and competitiveness. This creates a system where childbirth is an industry (a $111 billion industry to be exact)[175] that incentivizes costly procedures, including more tests and scans.[176] For example, in a low-risk pregnancy, ultrasounds are unnecessary; however, most obstetrician-gynecologists (OBGYNs) do not communicate this to their patients, and instead require their patients to get two (or more) ultrasounds as part of regular prenatal care.[177] A standard ultrasound costs around $410.[178] This results in a situation where people are unaware that their prenatal expenses could be significantly lower if their doctor lacked these incentives to increase prenatal costs and were transparent about which procedures were unnecessary. Additionally, obstetricians are trained surgeons, making them more expensive than midwives;[179] yet obstetricians oversee almost all childbirths regardless of whether they are low- or high-risk pregnancies, resulting in maternity care accounting for one-fifth of all healthcare expenditures in the United States.[180] This extremely expensive childbirth industry does not benefit women and parents when considered in light of the country's comparatively substandard birth rates. These expenses correlate with women's inability to afford prenatal care in the United States, and subsequently worse birth outcomes.[181]

In Europe, where maternity expenditures are notably lower,[182] 70% of women give birth with the assistance of midwives in hospital settings, and for low-risk

175. *See* Brown, *supra* note 6, at 6.

176. *See* Ester Bloom, *It Costs $27,000 More to Give Birth in the US Than It Does in the UK—Here's Why*, CNBC (Sept. 25, 2017, 12:37 PM), https://www.cnbc.com/2017/09/25/how-much-less-it-costs-to-give-birth-in-the-uk-than-in-the-us.html [https://perma.cc/4WJ8-4CG4].

177. *See Ultrasound: Sonogram*, AM. PREGNANCY ASS'N, https://americanpregnancy.org/prenatal-testing/ultrasound/ [https://perma.cc/JT2M-7CD5] (last visited Aug. 26, 2022); *Ultrasounds During Pregnancy: How Many and How Often?*, BETH ISRAEL DEACONESS MED. CTR. (Sept. 18, 2018), https://www.bidmc.org/about-bidmc/wellness-insights/pregnancy/2018/09/ultrasounds-during-pregnancy-how-many-and-how-often [https://perma.cc/PZZ7-8MHX].

178. *See* Ashley Brooks, *How Much Does an Ultrasound Cost Without Insurance in 2021?*, MIRA (Aug. 23, 2022), https://www.talktomira.com/post/how-much-does-an-ultrasound-cost-without-insurance [https://perma.cc/M4EA-E4KH].

179. *See* Slessor, *supra* note 127, at 521–22 ("In the world of for-profit health care, it is significant that using the service of a midwife is much less expensive than using an OB/GYN. By eliminating midwives, hospitals force women to choose the more expensive OB/GYNs as birth attendants, thus making more money off women who give birth. In fact, it costs nearly twice as much to go to a hospital than to a birth center." (footnotes omitted)).

180. Brown, *supra* note 6, at 5–6.

181. *See id.* at 6.

182. *See* Bloom, *supra* note 176 (noting it costs on average $27,000 more to have a baby in the United States than in the UK); *see also* Womersley, *supra* note 1 ("The U.K. has achieved these results

pregnancies, no obstetrician is present throughout the entire pregnancy and birth.[183] In the UK for example, where midwives oversee half of births, hospitals are not run as businesses but as nonprofits because the UK has implemented universal healthcare.[184] Thus, patients pay little or nothing, with the state setting the paygrade for doctors.[185] This encourages noncompetitive collaboration between doctors and midwives by removing the economics from the picture and disincentivizing unnecessary yet costly testing and scans, in turn saving the state money.[186] For low-risk births, women in the UK are also encouraged by the UK's National Institute for Health and Care Excellence to stay home,[187] the advantages of which include no risk of hospital-acquired infections[188] and decreased costs for hospital rooms and obstetricians. This creates drastically different outcomes between UK and U.S. care. For example, "[o]ne in 1 million women die of preeclampsia in the U.K.; that's less than a single death per year. By contrast, preeclampsia killed an estimated 50 to 70 women in the U.S. in 2016, accounting for 8 percent of maternal deaths. According to the most recent data available, hemorrhage is responsible for 6.5 percent of maternal deaths in the U.K. versus 11.4 percent in the U.S."[189]

The UK also considers maternal death a serious abnormality and addresses it as a public health failure that demands investigation by the state.[190] Further, the overarching notion during the childbirth process is that the patient is in charge; "[o]therwise you start undermining individual women's autonomy and then you go down a slippery slope."[191] Finally, with universal healthcare, the UK is able to standardize quality of care nationwide, which improves the basic care all parents

---

while spending less on delivering babies. On average, the total price charged for a vaginal birth in the U.S. is $30,000 (£24,000), which rises to $50,000 (£39,000) for a cesarean section . . . . [I]n the U.K. the average cost for a normal delivery or planned cesarean section on a hospital labor ward in 2016 was $2,300 (£1,755), while a complicated case . . . rose to $3,400 (£2,582).").

183. Brown, *supra* note 6, at 6–7.

184. *See id.* at 7. The UK and United States have somewhat comparable histories regarding racism and their involvement in the Atlantic slave trade. However, it should be noted that while about 14% of Americans identify as Black, only about 3.3% of those in England and Wales identify as Black. *See* Tamir et al., *supra* note 44; *Population of England and Wales*, GOV.UK (Aug. 7, 2020), https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest [https://perma.cc/9QVP-DCFT].

185. Brown, *supra* note 6, at 7.

186. *See id.*

187. *See id.* ("[G]uidelines issued in 2014 by the U.K.'s National Institute for Health and Care Excellence (NICE) recommend that women with low-risk pregnancies stay at home to give birth or give birth in midwife-led hospital units. According to the NICE report, 'evidence now shows midwife-led units to be safer than hospital[s] for women having a straightforward (low risk) pregnancy[.]'" (footnote omitted)).

188. *See id.* at 9 (explaining that scalpel usage during birth in hospitals can easily lead to complications or hospital-acquired infections).

189. Womersley, *supra* note 1 (noting that the standards for obstetricians and gynecologists are posted online, so women know what to expect of their doctors and midwives; this encourages patients to stay informed, which creates overall better birth outcomes).

190. *See id.*

191. *Id.*

and children receive.[192] As a result, in the UK, there is no statistically significant difference in mortality rates between mothers and children of different socioeconomic classes, nor any serious differences in healthcare quality.[193]

The United States approaches maternal health completely differently. The country treats a mother dying in childbirth as a "private" tragedy disconnected from the flaws and disparities ingrained in the healthcare system.[194] If investigated, these deaths often prompt local institutional reform instead of nationwide change.[195] Additionally, the United States lacks the same level of hospital standardization as the UK.[196] Due to race- and wealth-based disparities, hospitals that serve lower-income areas with higher rates of people of color have worse standards of care and significantly higher rates of maternal and infant death.[197]

Based on the variation in the quality of doctors and hospitals, a woman at one hospital may prematurely receive invasive procedures, such as a cesarean, while a similarly situated woman at a different hospital may avoid such a surgery.[198] The national average for cesareans is 32.2%, although this number varies wildly between hospitals, with many low-risk pregnancies resulting in unnecessary cesareans and complications from the procedure, including sepsis and hemorrhaging.[199] The reasoning behind the inconsistency of cesareans is once again economic: the surgical procedure heightens convenience for hospital staff, providing a higher patient-turnover rate to keep the business generating income, and increasing profits—a cesarean costs the patient on average almost $10,000 more than a vaginal birth.[200]

A National Bureau of Economic Research (NBER) study supports the finding that economic incentives dictate cesarean rates, with obstetricians more likely to perform unscheduled cesareans when there is a financial incentive to do so.[201] This includes unconscious bias: studies show that even the most trustworthy and judicious obstetricians are more likely to choose a cesarean when there are

192. *See* Bloom, *supra* note 176.

193. *See id.*

194. Womersley, *supra* note 1.

195. *See id.*

196. *See* Bloom, *supra* note 176.

197. *See id.*

198. *See* Brown, *supra* note 6, at 10.

199. *See id.* at 9–10.

200. *See id.* at 5–6, 10 (describing childbirth as an "industry" and noting the over-prescription of cesareans); Charlotte Cowles, *How Much Does It Actually Cost to Give Birth?*, THE CUT (Dec. 14, 2018) https://www.thecut.com/2018/12/how-much-does-it-actually-cost-to-give-birth.html (noting that the average total vaginal delivery cost, including prenatal, intrapartum, and postpartum care equals $22,734, while the average cesarean delivery total, also including prenatal, intrapartum and postpartum care, equals $32,062).

201. *See* Shankar Vedantam, *Money May Be Motivating Doctors to Do More C-Sections*, NPR (Aug. 30, 2013, 3:06 AM) https://www.npr.org/sections/health-shots/2013/08/30/216479305/money-may-be-motivating-doctors-to-do-more-c-sections [https://perma.cc/ZUZ5-QT9R] (citing Erin M. Johnson & M. Marit Rehavi, *Physicians Treating Physicians: Information and Incentives in Childbirth* (Nat'l Bureau of Econ. Rsch., Working Paper No. 19242, 2013)).

financial incentives.[202] Moreover, doctors themselves make a few hundred more dollars from cesareans than vaginal births, while hospitals can make a few thousand more, incentivizing both doctors and hospitals to call for a cesarean even when it may be unnecessary.[203] Notably, obstetricians also perform fewer cesareans on patients who are also doctors, indicating a correlation between fewer unnecessary procedures and well-informed patients.[204] "The idea is that physicians have medical knowledge," one NBER researcher stated.[205] "If the obstetrician is deviating from the best treatment because of their own financial incentive, the patient [who is a] doctor would be able to push back against the obstetrician. But that might not be the case for nondoctors because they simply do not have the medical knowledge to know whether or not this C-section is the appropriate [method of delivery] for them."[206] This highlights the need for non-doctor patients to have more informed autonomy and advocacy within the birthing room. Without information, patients become victims of hospital policies that benefit doctors, not patients.[207]

Implementing a universal healthcare system would solve this issue. This reform would create more space for midwives in the birthing room as it would eradicate market competition between midwives and doctors. Moreover, it would reduce the country's high cesarean rates by removing financial incentives to perform cesareans and by having midwives involved in the birthing process who are able to advocate for less invasive birth procedures.

Universal healthcare would also provide more access to maternity care, especially for Black women.[208] In the United States, financial and bureaucratic barriers to insurance disproportionately impact Black women. For example, 13% of Black women of reproductive age are currently uninsured and "many more experience gaps in coverage during their lives."[209] For white women of reproductive

202. *See id*.

203. *See id*.

204. *See id*.; *see also* Johnson & Rehavi, *supra* note 201, at 10, 27 (discussing physician-patients avoiding over-prescription of unnecessary medical procedures).

205. Vedantam, *supra* note 201.

206. *Id*. ("[D]octors are about 10 percent less likely to get C-sections . . . . [O]bstetricians appear to be treating their physician patients differently than [they treat] their nonphysician patients.").

207. *See* Brown, *supra* note 6, at 14.

208. *See infra* Section IV.B for a discussion on Medicaid expansion specifically in the South and how this would create better access to maternity care for Black women. While Medicaid expansion and universal healthcare are not the same thing, the overarching notion is that greater government-led financial medical coverage creates more avenues to access medical care. Thus, while more Medicaid coverage of maternity care would create better avenues of access, universal healthcare and free maternity care would further expand access to care. *See also* BERNETA L. HAYNES, NAT'L CONSUMER L. CTR., THE RACIAL HEALTH AND WEALTH GAP: IMPACT OF MEDICAL DEBT ON BLACK FAMILIES 2 (2022) (explaining that Black communities as a whole are disproportionately impacted by medical debt, with 27.9% of Black households carrying some form of medical debt compared to 17.2% of white households).

209. *See* NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 3; *see also id*. at 1 ("Compared to white women, Black women are more likely to be uninsured, face greater financial barriers to care when they need it, and are less likely to access prenatal care." (footnotes omitted)).

age, this number is only 8%.[210] Because Black women are more likely to be unable to access insurance, they are more likely to be unable to access prenatal and postnatal care, which results in more dangerous pregnancies. And because hospital prices are exorbitant without insurance, Black women are also more likely to incur medical debt when giving birth and face restrictive financial barriers to options that would make their birthing process more comfortable—an epidural alone tacks on $2,132 to the hospital bill.[211]

Finally, "[c]hildbirth is a leading reason for hospitalization among women of reproductive age."[212] In other words, childbirth is one of the most likely causes of why a woman of reproductive age would pay a hospital bill for an inpatient procedure. Yet, the cost of the bill is exorbitantly high, especially without insurance. Universal healthcare would not only eradicate or greatly lower the cost of childbirth in hospitals; it would also offer significantly more affordable access to prenatal and postnatal care, which would make pregnancies for Black women safer, particularly for those unable to obtain insurance.

Unfortunately, the United States has wrestled with universal healthcare for years and consistently failed to embrace it. Because universal healthcare is not necessarily a realistic goal, covering midwives under Medicaid may provide a more achievable solution.

B. COVERING MIDWIVES UNDER MEDICAID

Medicaid coverage has two main issues: (1) pregnant people face prohibitively high co-pays that prevent them from receiving prenatal care and (2) hospitals and obstetricians are expensive, resulting in high costs covered by Medicaid. The best way to alter Medicaid is for states to pioneer new approaches to maternal care. If states were to promote midwives as a realistic maternity care option, this would result not only in healthier babies, but also in cheaper medical costs for the state under Medicaid, saving the system more than $2,000 per birth.[213] For example, a low-risk vaginal birth in a hospital costs Medicaid on average $15,000; in a midwife-led birth center, this same birth would cost $3,700.[214]

---

210. *See* NAT'L P'SHIP FOR WOMEN & FAMS., DESPITE SIGNIFICANT GAINS, WOMEN OF COLOR HAVE LOWER RATES OF HEALTH INSURANCE THAN WHITE WOMEN 1 tbl.1 (2019), https://www.nationalpartnership.org/our-work/resources/health-care/women-of-color-have-lower-rates-of-health-insurance-than-white-women.pdf [https://perma.cc/GEX3-PM2U].

211. *See* Kara Brandeisky, *Here's What It Costs to Actually Become a Mother*, MONEY (May 6, 2016), https://money.com/childbirth-cost-insurance-mother/ [https://perma.cc/T8TG-CAU4].

212. Michelle Moniz, Vanessa Dalton, Lindsay Admon & Mark Fendrick, *Having a Baby May Cost Some Families $4,500 Out-of-Pocket, Study Finds*, U. MICH. INST. FOR HEALTHCARE POL'Y & INNOVATION (Jan. 6, 2020), https://ihpi.umich.edu/news/having-baby-may-cost-some-families-4500-out-pocket-study-finds [https://perma.cc/2J6F-F4M9].

213. *See* Doughton, *supra* note 2.

214. *FAQ - Licensed Midwifery in Washington State (2021)*, MIDWIVES' ASS'N OF WASH. STATE, https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/lm_licensed_midwifery_in_washington_state_fact_sheet_2021__1_.pdf [https://perma.cc/AGU2-UBCM] (last visited June 26, 2022).

Medicaid covers almost 50% of births in the United States and is "the largest payer of family planning and maternal health care services."[215] Although the Affordable Care Act (ACA) has greatly expanded healthcare coverage, not all states have adopted this expansion.[216] This issue is particularly prevalent in Southern states, where about 50% of the Black population lives[217] and which statistically have worse health outcomes for women.[218] Further, 61.1% of Medicaid beneficiaries are people of color,[219] with Black women depending more on Medicaid for prenatal care.[220] Moreover, 13% of Black women of reproductive age are unable to obtain any health insurance and many more experience insurance gaps throughout their lives.[221] Many Black women, mostly in Southern states with unexpanded Medicaid coverage, also live in a "coverage gap," meaning they earn too much to qualify for Medicaid, but not enough to buy health insurance under the ACA, and thus are uninsured[222]—in fact, there is a correlation between lack of healthcare expansion and coverage gaps, with 92% of Americans who fall into this gap living in the South.[223]

This failure to expand Medicaid upholds racial inequalities because it disproportionately affects Black Americans, leaving 14% of Black Americans in non-expansion states without health insurance, whereas only 8% lack health insurance in expansion states.[224] In comparison, 10% of white Americans in non-expansion states lack health insurance, and only 6% in expansion states.[225] Evidence suggests that if these states were to expand their Medicaid coverage under the ACA, nearly 60% of currently uninsured Black adults would be eligible for coverage.[226] However, without expansion, health insurance continues to contribute to the disparity between Black and white infant and maternal mortality rates. Due to this disparity, pregnant people without health insurance face such high barriers to prenatal care that they often cannot see a medical provider during the first trimester,

215. *See* Taylor, *supra* note 45, at 513.

216. *See id*.

217. *Id*.

218. NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 3.

219. MEDICAID & CHIP PAYMENT & ACCESS COMM'N, RACIAL AND ETHNIC DISPARITIES IN MEDICAID: AN ANNOTATED BIBLIOGRAPHY (2021), https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf [https://perma.cc/PE4G-NDW7].

220. Christine Herman, *With Black Women at Highest Risk of Maternal Death, Some States Extending Medicaid*, NPR (May 25, 2021, 11:58 AM), https://www.npr.org/sections/health-shots/2021/05/25/999249316/with-black-women-at-highest-risk-of-maternal-death-some-states-extending-medic ai [https://perma.cc/B8H9-GETE].

221. NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 1, 3.

222. *Id*. at 3; Taylor, *supra* note 45, at 513 ("[I]n states that have not expanded Medicaid, many American families still face challenges in gaining coverage—especially if they make too much to meet the traditional Medicaid income threshold, lack affordable coverage options through an employer, do not qualify for premium subsidies through marketplace plans, or lack sufficient income to pay for coverage out of pocket. These burdens fall hardest on low-income families of color.").

223. *See* Taylor, *supra* note 45, at 513.

224. *Id*.

225. *Id*.

226. *See* CTR. FOR REPROD. RTS., *supra* note 46, at 4.

which is associated with higher rates of maternal mortality; because Black people are more likely to lack health insurance, this makes it more likely that pregnant Black people specifically will be unable to procure prenatal care.[227] Moreover, expansion may help keep rural Southern hospitals afloat because it enables more low-income individuals, especially those in Black communities, to afford hospitals via insurance. However, likely in part because these states have not expanded Medicaid, hospitals in the South continue to be prohibitively expensive for the surrounding communities and are eventually shut down, leaving members of these communities without convenient medical care.[228]

Black women are also more likely to face unemployment or pregnancy discrimination in the workplace, with Black women comprising only 14% of women ages 16 to 54 in the workforce but making up nearly 30% of pregnancy discrimination claims filed between 2011 and 2015.[229] This discrimination can lead to loss of "critical income" for pregnant Black women, or even loss of health insurance, leading to more dangerous pregnancies.[230] Moreover, as America's wealth inequality gap increases, Black women continue to be disproportionately affected—since the 2008 recession, median household income has dropped dramatically, with Black women twice as likely to be unemployed as white women.[231] All of these employment factors create barriers for Black women to obtain health insurance through an employer or afford insurance while on minimum-wage salaries.[232] Due to these economic barriers, many Black women obtain Medicaid coverage only during their pregnancy, which ends sixty days after giving birth; yet an estimated 20% of pregnancy-related deaths happen between forty-three days and one year after giving birth.[233] Therefore, maternal health experts claim that extending Medicaid coverage to a full year postpartum could save a significant number of lives, particularly the lives of Black women.[234] States' reluctance to expand Medicaid thereby actively perpetuates dangerous pregnancies for Black people.

The ACA creates additional barriers. While the ACA requires full coverage of preventative care, such as pap smears and mammograms, it conspicuously does not demand full coverage for maternity care even though childbirth is a leading reason for hospitalization among women of reproductive age.[235] Instead, the ACA permits insurance plans to impose high co-pays and deductibles on pregnant people, resulting in many parents paying out-of-pocket for at least some of their pregnancy costs.[236] For example, in 2015, an out-of-pocket vaginal birth had

227. *See* NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 3.
228. *See supra* notes 72–75 and accompanying text.
229. *See* NAT'L P'SHIP FOR WOMEN & FAMS., *supra* note 42, at 4–5.
230. *See id.* at 5.
231. *See* CTR. FOR REPROD. RTS., *supra* note 46, at 3.
232. *See id.* at 3–4.
233. *See* Herman, *supra* note 220.
234. *See id.*
235. *See* Moniz et al., *supra* note 212.
236. *See id.*

a mean cost of over $4,000, with women covering on average 21% of the total expenses; cesareans cost more than $5,000 out-of-pocket, with women covering 15% of the total expenses.[237] Evidence shows these numbers are rising, often due to delayed or skipped care, with pregnant people paying more each year.[238] This results in pregnant people still paying hundreds of dollars alone just to birth their child, on top of the already expensive prenatal care.

While Medicaid expansion plays a role in improving Black birth outcomes, covering midwives under Medicaid also addresses issues of care accessibility and affordability. Midwives would better monitor mothers before and after birth and would be cost-effective for states by providing more personal prenatal care and offering emotional support to Black mothers, leading to safer birth scenarios.[239] For example, Black mothers face high barriers to access postpartum care up to one year after giving birth. While this care would be prohibitively expensive if performed by obstetricians, midwives could provide this care under Medicaid for a fraction of the cost, creating a cheaper and more accessible solution for rural or low-income pregnant people, including women of color.[240] Research also shows an association between midwifery care of "at-risk" populations and significantly reduced incidence of pre-term birth, low birth weight, and other adverse outcomes, likely due to midwives' financial accessibility and advocacy for patients.[241] Midwives would also save states money—one study found that midwife-led low-risk births in hospitals cost on average $2,262 less than those led by obstetricians.[242]

---

237. *Id.*

238. *See id.*

239. *See* Vedam et al., *supra* note 133, at 11; Villarosa, *supra* note 50 (explaining how doulas, like midwives, offer personal emotional support to pregnant women of color, which results in decreased maternal stress and risk of dangerous births).

240. *See* Karen Miles, *Midwife vs Doctor: Which is Right for You?*, BABYCENTER (Aug. 10, 2021), https://www.babycenter.com/pregnancy/health-and-safety/doctor-or-midwife-which-is-right-for-you_9348 [https://perma.cc/6RBS-BGQ3] ("The costs of childbirth with a midwife are, on average, just over $2,000 less expensive than childbirth under the care of an obstetrician."). Note that this solution would also require state midwifery boards to carefully oversee the practice to ensure midwives meet standards and treat patients fairly and equally. *See* Courtot et al., *supra* note 63, at 1094–95 (noting that midwives are more likely to take a holistic and culturally sensitive approach to their patients: "Standards for the midwives' model emphasize individualized approaches, including culturally sensitive care, patient and family engagement, shared decision making, and education and health promotion, all attributes that women say they value in prenatal and birth care. Personalized, longer visits may allow women to reveal needs such as food insecurity or depression that can then be addressed. . . . Because prenatal visits generally lasted at least 30 minutes, midwives had enhanced capacity to build relationships and identify individual patient needs." (footnotes omitted)). To continue this trend as midwifery grows in popularity, state midwifery boards must ensure all midwives are trained to adequately support patients of different races and cultural backgrounds.

241. *See* Vedam et al., *supra* note 133, at 11 ("A recent population-level analysis in Canada described associations between midwifery care of at-risk populations and significantly reduced incidence of pre-term birth, low birth weight, and other adverse outcomes.").

242. Laura B. Attanasio, Fernando Alarid-Escudero & Katy B. Kozhimannil, *Midwife-Led Care and Obstetrician-Led Care for Low-Risk Pregnancies: A Cost Comparison*, 47 BIRTH ISSUES IN PERINATAL CARE 57, 57 (2019).

Unfortunately, the current Medicaid system fails to reflect these aforementioned goals. While the ACA requires health insurance companies to give certified midwives the opportunity to join networks, insurers can still restrict their practice by demanding that patients give birth in hospitals or birth centers.[243] Moreover, some states do not recognize non-nurse midwives as legal practitioners, restricting potential insurance coverage further.[244] Therefore, the first step to give patients more access to midwives is to have Medicaid and the ACA cover licensed midwives (nurse *and* non-nurse) and promote these midwives as realistic alternatives to obstetricians, especially for low-risk pregnancies. The next step is for Medicaid to cover the full costs of prenatal care, especially if this care is led by midwives. Currently "twenty-seven states do not require private insurance companies to pay for nurse-midwife or midwife-assisted births and most other states only reimburse midwife-assisted births if they occur in hospitals."[245] This creates prohibitive costs and bars insured pregnant people from accessing midwifery care. Without access to cheaper, more equitable maternity care options, Black people, especially those on Medicaid, are less likely to receive care—prenatal, during childbirth, and postpartum—and therefore face dangerous pregnancies.

Expanding Medicaid to cover midwives would also create greater fundamental access to midwives. Particularly, if more midwives are trained, schooled, and licensed, they would be more likely to concentrate in higher-income communities, which would perpetuate current inequities. However, if more midwives are trained and covered under Medicaid, this would create greater opportunities for low-income people to overcome barriers to access and thus receive the care of a midwife.

While expanding state coverage of Medicaid could serve as a viable solution to barriers preventing pregnant people from accessing maternity care, it seems unlikely that states that have not already expanded Medicaid under the ACA would be willing to do so now. However, covering the costs of midwifery under Medicaid is more realistic in light of recent state action indicating a rising legislative interest in this goal: states are currently advancing legislation that would cover midwives and doulas under Medicaid or private insurance and promote increasing numbers of non-nurse midwives.[246] Therefore, addressing poor state birth outcomes by covering midwives under Medicaid is a realistic option for states because it does not require the same level of institutional change as ACA expansion and recent legislation appears to have an eye toward this goal.

---

243. *See* Elizabeth Renter, *How Much Do Homebirths Actually Cost?*, FOX NEWS (Oct. 27, 2015, 3:00 AM), https://www.foxnews.com/health/how-much-do-home-births-actually-cost [https://perma.cc/KB83-6VZ9].

244. *See id.*; *see also supra* Section II.B (discussing Pennsylvania's regulatory scheme and non-recognition of non-nurse midwives as nurse practitioners).

245. Thompson, *supra* note 13, at 44.

246. *See* Wright, *supra* note 170.

C. TRAINING MORE MIDWIVES IN SOUTHERN STATES

Increasing the supply of midwives would significantly decrease socioeconomic birth disparities between Black and white populations. Unfortunately, reality does not reflect this goal, as states with higher Black populations have fewer midwives and restricted access to the few existing ones.[247] However, research suggests that with greater midwife integration, these states would see reduced rates of difficult pregnancies and pregnancy-related deaths in Black women, among other long-term benefits.[248] This Section therefore recommends Southern states, such as Alabama,[249] promote affordable midwifery training and education.

Non-nurse midwives do not attend medical school—instead, these midwives can learn the trade by either obtaining a master's degree (on average, a three-year commitment after a bachelor's degree[250]) or apprenticing, making their education faster and cheaper than an obstetrician's. Washington State has embraced this form of midwifery by creating a three-year program to obtain a license, requiring trainees to attend at least one hundred births and pass state exams.[251] Washington also permits midwives to apprentice instead of attending school.[252] These apprentice midwives can be licensed, provided that they attend over one hundred births, pass all required exams, and take a handful of accredited courses.[253] While Washington possesses high levels of midwife integration, socioeconomic factors also give the state an edge in birth outcomes: Washington had a median income of $78,687 in 2019 (almost $13,000 *above* the national median of $65,712),[254] whereas Alabama had a median income of $51,734 in 2019 (almost $14,000 *below* the national median).[255] Additionally, the racial and age demographics of each state are different. According to the 2020 census, Washington's population is composed of a white community of 66.6% and a Black or African-American community of 4%,[256] and in 2019, 7.7% of non-elderly people in Washington

247. *See* Vedam et al., *supra* note 133, at 15.

248. *Id.* at 11 ("Density of midwives and access to midwives across birth settings were also significantly lower in states where more black babies are born. [Evidence] suggests that, with greater integration of midwives in these states, the associated reduced rates of neonatal mortality, preterm birth, and increased breastfeeding success could confer important long term health benefits for African American mothers." (footnotes omitted)).

249. *See supra* Section I.C (discussing Alabama's struggles with maternity care).

250. *See* Vedam et al., *supra* note 133, at 3 (referring to non-nurse midwives as "direct-entry midwives").

251. *See* Doughton, *supra* note 2.

252. *See id.*

253. *See id.*

254. *See Washington Household Income*, DEP'T OF NUMBERS, https://www.deptofnumbers.com/income/washington/ [https://perma.cc/8UXL-YC73] (last visited Aug. 27, 2022).

255. *See Alabama Household Income*, DEP'T OF NUMBERS, https://www.deptofnumbers.com/income/alabama/ [https://perma.cc/AWE9-VV9B] (last visited Aug. 27, 2022).

256. *See* America Counts Staff, *Washington State Grew by Almost 1 Million*, U.S. CENSUS BUREAU (Aug. 25, 2021), https://www.census.gov/library/stories/state-by-state/washington-population-change-between-census-decade.html (note that these statistics do not account for mixed-race people).

were uninsured.[257] Conversely, Alabama had a white community of 64.1% and a Black or African-American community of 25.8%,[258] and in 2019, 12.1% of the non-elderly population was uninsured.[259] Thus, while Washington State demonstrates realistic measures other states can take to train high-quality midwives, other factors such as insurance coverage, median income, and institutional racism must be taken into account when considering why Washington's maternal and infant survival rates are so high. Finally, although Washington has the highest midwife integration rates, midwives still only oversee 13.4% of births in the state,[260] as opposed to the UK's more than 50%.[261] This Section recommends not only how states could implement measures similar to Washington's but also how states could increase their usage of midwives overall, particularly in Black communities.

The first step is for states to have more practicing midwives. In Southern states, creating accessible paths for people to gain a midwifery education through low-cost apprenticeships would create opportunities for Black community members to become midwives. State midwifery boards could visit rural and low-income high schools to discuss midwifery as an option, especially for students interested in the medical field but who cannot afford college or medical school. To ensure the safety of midwifery practice, states could draw from Washington's strict licensing procedures by administering standardized tests and requiring trainees to attend a certain number of births with licensed midwives.[262] However, standardized testing is commonly used to gatekeep low-income people and people of color from higher education and certain professions.[263] Therefore, Southern states—which are home to a high number of low-income residents and a majority of this country's Black population[264]—may have more equitable outcomes by focusing on offering high-quality accredited classes. States

257. *See* KENNETH FINEGOLD, ANN CONMY, ROSE C. CHU, ARIELLE BOSWORTH & BENJAMIN D. SOMMERS, ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OFF. OF HEALTH POL'Y, TRENDS IN THE U.S. UNINSURED POPULATION, 2010–2020, 11 (Feb. 11, 2021), https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf [https://perma.cc/HK3B-WH48] (note that during the 2020 pandemic, these numbers were subject to change).

258. *See* America Counts Staff, *Alabama Population Grew 5.1% Since 2010, Surpassing 5 Million*, U.S. CENSUS BUREAU (Aug. 25, 2021), https://www.census.gov/library/stories/state-by-state/alabama-population-change-between-census-decade.html (note that these statistics do not account for mixed-race people).

259. *See* Finegold et al., *supra* note 257, at 10 (note that during the 2020 pandemic, these numbers were subject to change).

260. *See State Scoring: Washington*, *supra* note 74.

261. *See* Brown, *supra* note 6, at 7.

262. Several states already require this. *See State Law Chart: Certified Professional Midwife Scope of Practice*, AM. MED. ASS'N, https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/arc/direct-entry-midwife-state-chart-practice-information-2016.pdf [https://perma.cc/F7GP-HBVB] (last visited Aug. 28, 2022). However, states do not actively promote the field of midwifery as a solution to low birthrates; they simply regulate it.

263. *See* Maddy Gates, *A Civil Rights Challenge to Standardized Testing in College Admissions*, HARV. C.R.-C.L. L.R.: AMICUS (Nov. 12, 2019), https://harvardcrcl.org/a-civil-rights-challenge-to-standardized-testing-in-college-admissions/ [https://perma.cc/XS2U-N8GC].

264. *See supra* notes 44–46 and accompanying text.

could hold these classes in community centers or colleges in rural areas. Not only would this increase Black rural pregnancy care, but it would also mitigate the effects of rural hospital closures and save states large amounts of money by making midwives accessible to Black, rural, low-income pregnant people so that they can rely less on obstetricians.[265]

Giving members of Southern Black communities more opportunities to enter the medical field would also advance the medical care of these communities as a whole. Increasing the number of Black medical providers correlates with increased access to healthcare for Black patients and higher levels of patient trust, and leaves Black patients more satisfied than with white medical providers.[266] In the medical field, only 4% of physicians are Black.[267] Creating avenues for members of Southern Black communities to become midwives would create a new, more accessible form of medical outreach for pregnancy care. Moreover, many of these communities rely on de facto segregated hospitals for medical care. Currently, 75% of Black women deliver their babies in 25% of America's hospitals, meaning that Black women disproportionately give birth in a limited number of hospitals that serve almost exclusively communities of color.[268] These hospitals have the highest rates of death or near-death experiences for pregnant people in the country.[269] While midwives alone cannot solve the institutional racism present in these hospitals, increasing midwives in communities that utilize these hospitals would give mothers more support and better medical representation, which would result in overall safer birthing scenarios.

Additionally, if a state spent funds promoting and training citizens in non-nurse midwifery, this would lessen the state's overall financial coverage of Medicaid bills because midwives are a significantly cheaper alternative and patients would only meet with obstetricians for high-risk pregnancies.[270] While Black people are more likely to experience high-risk pregnancies, over time the number of high-risk pregnancies would likely decrease because midwives could provide cheaper and more extensive prenatal and in-birthing room care, which correlates with significantly better pregnancies, births, and postnatal survival rates. In fact, data from other countries shows a decreased maternal mortality rate following the

265. *See* Kennedy Austin, *End Racial Disparities in Maternal Health, Call a Midwife*, COLUM. MAILMAN SCH. OF PUB. HEALTH (Feb. 2, 2020), https://www.publichealth.columbia.edu/public-health-now/news/end-racial-disparities-maternal-health-call-midwife [https://perma.cc/D45D-GZT2] ("[F]or those in states like Georgia where 79 counties lack an OB/GYN, a midwife might be the difference between life and death. Representation and implicit bias courses are wholly insufficient to fix a national crisis.").

266. *See* CTR. FOR REPROD. RTS., *supra* note 46, at 6 & n.75.

267. *See id*. at 6.

268. *Id*. at 5.

269. *Id*. at 5–6.

270. *See* Doughton, *supra* note 2; *see also* Vedam et al., *supra* note 133, at 12 ("Our results align with this evidence suggesting that increased reliance on midwives could reduce the costly overuse of obstetric interventions, reduce rates of preterm birth and neonatal loss, and improve breastfeeding and vaginal birth rates, thereby helping to address serious maternal-newborn health deficits in the United States.").

nation's targeted financial investment in midwifery services—states could take this same targeted approach by funding the training of midwives.[271]

This approach would have better success than current obstetric care because midwifery care that focuses more on Black people and employs more Black people as midwives would advance education on the differences between Black and white pregnancies and dispel myths regarding Black patient care. Problematically, 50% of white medical trainees currently believe medical myths that began during the slave era, including that Black people "have thicker skin or less sensitive nerve endings than white people."[272] These beliefs in medical myths results in Black patients receiving fewer pain relievers and worse care.[273] In fact, Black and Latinx populations receive worse medical care than white people an estimated 40% of the time; if they live in poverty, this number rises to 60%.[274] Additionally, the phenomenon of "weathering" results in Black women's bodies aging faster than white women's;[275] this means a Black woman in her late twenties is more likely to have issues associated with geriatric pregnancies, even though geriatric pregnancies are currently only defined as a pregnant woman of any race over thirty-five.[276] While this definition of geriatric pregnancy may be appropriate for white patients, prenatal care providers of Black patients should be more watchful of young pregnant Black patients for any signs of the pregnancy

---

271. *See* Vedam et al., *supra* note 133, at 13 ("A recent Lancet analysis of maternal health policy revealed that countries with a sustained 20-year decrease in maternal mortality had increased country-wide access to health care through targeted investment in midwifery services. In countries like India, Mozambique, Uganda, and Nepal skilled birth attendants are scarce in all settings and the consequences are disastrous—'too little too late.' In high resource countries that are experiencing the phenomena of 'too much, too soon', expanding availability of midwives across health systems also has important implications for quality, safety, and cost-effectiveness." (footnotes omitted)).

272. Janice A. Sabin, *How We Fail Black Patients in Pain*, ASS'N OF AM. MED. COLLS. (Jan. 6, 2020), https://www.aamc.org/news-insights/how-we-fail-black-patients-pain [https://perma.cc/G9M3-MAJQ]; CTR. FOR REPROD. RTS., *supra* note 46, at 6 ("Past and present experiences with racial discrimination shape Black patients' interactions with their medical providers, and stereotypes, implicit bias, and mistrust continue to interfere with care. Studies show that Black patients are treated differently than White patients with the same symptoms, receiving fewer diagnostic and therapeutic interventions, and even less pain medication.").

273. *See* Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PROC. NAT'L ACAD. SCI. 4296, 4296 (2016); *see also* Sabin, *supra* note 272 (discussing disparities in pain treatment as a result of implicit biases).

274. *See* CTR. FOR REPROD. RTS., *supra* note 46, at 5.

275. *See supra* Section I.B for a discussion on weathering; *see also* Martin & Montagne, *supra* note 53 ("The effects on the mother's health may also be far-reaching. Maternal age is an important risk factor for many severe pregnancy-related complications, as well as for chronic diseases that can affect pregnancy, like hypertension. 'As women get older, birth outcomes get worse, . . . [i]f that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s.' This means that for black women, the risks for pregnancy likely start at an earlier age than many clinicians—and women— realize, and the effects on their bodies may be much greater than for white women. This doesn't mean that pregnancy should be thought of as inherently scary or dangerous for black women (or anyone). It does mean . . . that 'a black woman of any social class, as early as her mid-20s, should be attended to differently'—with greater awareness of the potential challenges ahead.").

276. *Geriatric Pregnancy*, WEBMD, https://www.webmd.com/baby/guide/pregnancy-after-35#1 [https://perma.cc/CUC5-XRYT] (last visited Aug. 27, 2022).

becoming high-risk. However, most providers currently do not approach Black patient's pregnancies with this vigilance due to both undereducation about Black patient's higher-risk pregnancies and implicit bias and race-related myths.

Midwives specifically trained to provide for Southern communities with large Black populations, and who are Black themselves, would better assist Black women because their education would not be based on health standards designed to serve white communities found in medical textbooks, but instead on experience apprenticing and working within the communities they serve.[277] In turn, this would decrease implicit bias and create safer birthing environments for Black mothers. This suggestion for midwifery training is relatively realistic because Washington State has already implemented several of these measures. Many young people are also interested in the medical field but cannot afford a nursing or medical degree. Midwifery education is comparatively inexpensive, could be done online or locally, and has a market demand. Thus, those who seek this education would have consistent business, especially in rural areas or areas where many people face high barriers to access insurance. Moreover, states are currently advancing legislation that would facilitate more people becoming direct-entry midwives.[278] This trend indicates that states are seeking to address their poor birth outcomes through midwifery, and implementing state-subsidized promotion of midwifery education could be of interest to legislators because it would save the state money and improve birth outcomes.

D. CREATING ACCESSIBLE BIRTH CENTERS OVERSEEN BY MIDWIVES

By sponsoring more midwife-run birth centers, especially in rural areas, low-income areas, and areas that lack Medicaid expansion, states would offer safe birthing environments in areas with few hospitals. Birth centers are a significantly cheaper option than giving birth in a hospital and would likely be a safer option for Black parents due to the patient-focused care midwives can offer.[279]

Birth centers are exactly what they sound like—locations where soon-to-be parents can receive prenatal care and give birth. These centers have many of the medical necessities needed for safe birth; however, they are run by midwives who avoid over-medicalizing the process. These centers must be licensed by the

277. *See* Walker et al., *supra* note 80 ("Educating midwives in the hospital may also limit the numbers of experiences students have with normal, physiologic birth practices. Faculty and preceptors are called upon to creatively support normal physiologic birth within that setting and role model the philosophy of 'being with women' in a compassionate way. Effects of the medicalized approach inherent in the hospital setting can also be mitigated by midwives maintaining a clear focus on what works best for women.").

278. *See* Wright, *supra* note 170.

279. Homebirths could potentially also be an option to avoid giving birth in hospitals. However, there is a dearth of information on the success of homebirths, especially those overseen by both a midwife and an assisting obstetrician, because this is an uncommon event. If more states embrace the practice of midwifery, this could potentially lead to a resurgence in safer homebirths where midwives are afforded access to medical technology and support. *See* Thompson, *supra* note 13, at 32–37, 43–45 (discussing the institutional barrier on midwifery practice and challenges in creating safer, more accessible avenues to homebirth).

state and are primarily used for low-risk pregnancies. Unfortunately, they are not popular, with only 310 known in the entire country in 2015,[280] and accounting for less than 1% of births.[281] The scarcity of birth centers is likely due to the general population's undereducation about their existence, creating less demand. In addition, because these centers rely on midwives' ability to practice medicine independently—something many states restrict—the success of birth centers is further hindered.

Although these centers are sparse, they are predominantly used by white women for prenatal, birthing, and postnatal care, with only about 23% of birth center births involving people of color and only 24% of such births involving women with Medicaid.[282] Recently, however, as midwifery has grown in popularity, there has been an increased interest in these centers among American women,[283] with a California survey of over 2,500 women finding that 45% of Black women and 41% of women covered by Medicaid were interested in birth centers.[284] This indicates that if these centers were made available and accessible under insurance, more underserved communities would likely utilize them to their benefit. Additionally, one study found that Black and Hispanic women on Medicaid who attended birth centers had fewer cesareans and more term births than women of equal risk who were overseen by obstetricians.[285] These factors can be attributed both to women receiving more attentive care during their births and to better prenatal care at birth centers, with prenatal care meetings typically lasting over double the amount of time with a midwife than with an obstetrician.[286] The length of time for these meetings can be attributed to midwives' holistic approach to prenatal care, creating individualized care plans, emphasizing culturally sensitive medical approaches, taking time to educate the patient on health, and integrating the patient and the patient's family into the decisionmaking process.[287] All of these factors foster safer births and create a better environment for pregnant people.

While Medicaid requires insurance coverage for birth centers, states vary in the application of this requirement and can accordingly limit the scope of midwifery practices occurring in these centers.[288] In general, insurance providers fail to meet the coverage standards that Medicaid demands for birth centers, limiting

280. *See* Jill Alliman & Julia C. Phillippi, *Maternal Outcomes in Birth Centers: An Integrative Review of the Literature*, 61 J. MIDWIFERY & WOMEN'S HEALTH 21, 21 (2016).

281. *See* Vedam et al., *supra* note 133, at 12.

282. *See* Courtot et al., *supra* note 63, at 1093.

283. *See* Vedam et al., *supra* note 133, at 12.

284. Courtot, *supra* note 63, at 1094.

285. *See id.*

286. *Id.* ("Midwifery may have particular benefits for women with psychosocial risks for poor birth outcomes. While most obstetricians indicate that a typical appointment lasts 16 minutes or less, the midwifery model of care emphasizes sufficient time to address holistic needs, and a prenatal care visit in a birth center is typically 30 minutes or longer." (footnotes omitted)).

287. *See id.*

288. *See id.*

pregnant people's access to these centers.[289] In a recent survey, about half of birth centers struggled to provide for Medicaid patients because Medicaid would not cover the baseline cost of care.[290] In this survey, at least three birth centers encouraged or required Medicaid patients to give birth in hospitals because Medicaid did not cover enough of the birth expenses at the center.[291] For example, one center that required Medicaid patients to give birth at hospitals did so because Medicaid would only reimburse the center $400 per birth, an amount that did not "even cover the cost of the labor nurse."[292] Thus, Medicaid patients are most often denied care by birth centers, even though these patients would actually benefit more than non-Medicaid patients from giving birth outside of hospitals.

States could also better equip birth centers to serve Black communities by having obstetricians collaborate with these centers. States could give obstetricians financial incentives to do so, such as yearly bonuses based on the number of hours an obstetrician volunteers at centers. Giving obstetricians incentives to oversee birth centers would enable people with higher-risk pregnancies to still enter these centers and receive midwife-centered care along with obstetrician care if necessary.[293]

While birth centers would help communities, this suggestion is unachievable unless legislation and states' stances on midwives change dramatically. To increase use of birth centers, states must first cover these options under insurance and then train more midwives who can be integrated into the healthcare system. Only *then* would birth centers be a realistic option. However, state legislation encouraging midwifery practice and usage of midwives is rising in America. Therefore, while this solution needs more groundwork to become realistic, it could become a viable option for states that continue to integrate midwives within the next few decades.

CONCLUSION

American maternity care is currently in a state of crisis. Not only are medical costs exorbitant, but Black communities continue to disproportionately lose parents and children. This Note offers ways to address these issues, particularly in Southern states where the populations are disproportionately uninsured or reliant on Medicaid. Midwives not only offer a means of outreach to low-income Southern rural Black communities but also offer higher standards of care to Black women of all socioeconomic classes who are at higher risk of maternal

289. *See id.* at 1094–95.
290. *Id.* at 1101.
291. *Id.* at 1103.
292. *Id.*
293. *Id.* at 1093 ("Birth center care is usually provided for women without pregnancy complications, though many birth centers routinely serve women with psychosocial risks and some have collaborative relationships with physicians that allow them to serve women with medical risks as well." (footnotes omitted)).

mortality due to weathering and institutional racism. However, licensing and economic issues continue to create barriers to access to midwives and hinder midwives' ability to care for patients. To make midwifery more accessible to all patients, the practice of midwifery must be protected from hospitals and physicians, which have historically made concerted efforts to monopolize obstetricians. The revival of civil suits and FTC investigations against hospitals and physicians who exclude midwives from practice for anticompetitive financial reasons that go against Section 1 of the Sherman Act may offer a means of protection. Finally, the best way to provide access to midwives is by implementing a universal healthcare system, but the United States will likely not do so in the near future. Therefore, other strategies, such as increasing Medicaid coverage of midwives, training midwives in rural areas, and creating realistic avenues to support birth centers could also improve birth outcomes, especially for low-income Black women in the rural South.