IN THE SUPREME COURT OF MISSOURI

Case No. SC88783

STATE OF MISSOURI and FRIENDS OF MISSOURI MIDWIVES, et al.,

Appellants,

v.

MISSOURI STATE MEDICAL ASSOCIATION, et al.,

Respondents.

Appeal from the Circuit Court of Cole County
Honorable Patricia Joyce, Circuit Judge
Case No. 07AC-CC00567

AMICUS CURIAE BRIEF
OF
Citizens for Midwifery
Midwives Alliance of North America
National Association of Certified Professional Midwives
Our Bodies, Ourselves
National Birth Policy Coalition

MARY J. BROWNING LLC
Mary J. Browning, #34633
214 Cherry Street
Jefferson City, MO 65101
Telephone No.: (573) 893-4523
Facsimile No.: (573) 893-4591
E-mail: mary@maryjbrowninglaw.com

Attorney for Amici

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

State Statutes

Miscellaneous

INTEREST OF AMICI

Citizens for Midwifery ("CfM") is a national, consumer-based non-profit organization promoting the Midwives Model of Care. Our members are primarily parents and concerned citizens, but include doulas, childbirth educators, midwifery students, midwives, nurses, and physicians. CfM works to improve access to the evidence-based, respectful Midwives Model of Care in all settings for all women. Certified Professional Midwives ("CPMs") are specifically trained to provide the Midwives Model of Care, which promote the health and well being of mothers and babies, which rarely is found within the hospital setting. CfM has a strong interest in the present litigation because the outcome will impact women, their babies and their families – whether women in Missouri will have access to legal midwives for out-of-hospital births. We have an additional interest in ensuring the accuracy of information about CPMs and planned, midwife-attended out-of-hospital birth that is conveyed to the Court.

Midwives Alliance of North America ("MANA") was established in 1982 as a professional organization for all midwives, recognizing the diversity of educational backgrounds and practice styles within the profession. MANA's focus is to unify and strengthen the profession of midwifery, thereby improving the quality of health care for women, babies, families and communities. MANA believes that every woman deserves to have access to competent care providers of her choice. Research shows that CPMs are skilled, safe and effective practitioners with excellent outcomes, and are experts in out-of-hospital birth. Barriers to the provision of legal and licensed midwives constitute an unnecessary risk for women and infants.

Our Bodies, Ourselves ("OBO," also known as the Boston Women's Health Book Collective) is an international women's health education and advocacy organization, working in the field of pregnancy and birth since 1970. OBO's first publication *Our Bodies, Ourselves* is now in its 8th edition. The focus of OBO is to empower women with accessible, research-based information about health, sexuality, and reproduction to support informed decision-making. We advance women's health and human rights within a framework of values shaped by women's voices, and a commitment to self-determination and equality. OBO creates and disseminates reliable, accessible resources that women use – individually and in groups – to change the norms, laws, and policies often limiting people's health, economic status, and roles in society.

The statutory provision at issue in this case before this Court speaks directly to the issue of a woman's right to choose a safe birthing option endorsed by the Royal College of Obstetricians and Gynecologists in the U.K. and the Society of Obstetrics and Gynecology in Canada. That the American College of Obstetrics and Gynecology has an official position opposing home birth speaks to the serious problems, here in the U.S., regarding the rational provision of maternity care in a way that best meets women's needs.

The National Association of Certified Professional Midwives ("NACPM") is the national professional society for certified professional midwives ("CPMs"). NACPM aims to increase women's access to professional midwives by removing barriers to care, educating legislators and policy makers and supporting the legal recognition of the CPM

on federal and state levels. NACPM represents CPMs throughout the United States, including several CPM members in the State of Missouri.

NACPM and its members have a strong interest in this case's outcome because the court below failed to recognize that CPMs are professional midwives, certified by the North American Registry of Midwives, that the CPM is accredited by the National Commission for Certifying Agencies (NCCA), the accrediting arm of the National Organization for Competency Assurance (NOCA), and the wide acceptance and authorization of CPMs practice by state governments, public and private health insurance providers, and the public. NACPM believes that Respondent's and *amicus curiae* AMA's arguments are inaccurate in their depiction of CPM's professionalism and national scope of practice and is concerned that Missouri CPMs may be subject to criminal liability unless the lower court decision is reversed and § 376.1753 RSMo is ruled constitutional. Perpetuation of criminal penalties against CPMs have a chilling effect upon consumers' access to CPMs and will inhibit CPMs' willingness to provide their safe, high-quality professional services to pregnant women.

In filing this brief, NACPM offers the Supreme Court of Missouri its clinical expertise with respect to CPMs' scope of practice and their regulation in other U.S. jurisdictions in order to supplement the factual and legal basis provided by the parties.

The **National Birth Policy Coalition** ("NBPC") is a coalition of national and state organizations of consumers, midwives, and activists in the fields of women's health and birthing rights who have endorsed the NBPC organizing statement to the effect that increasing access to the Midwives Model of Care in all settings is essential to the health

and well-being of childbearing women and their babies. The NBPC promotes the autonomous practice of CPMs and Certified Nurse-Midwives, and seeks to ensure the availability of safe, evidence-based care during pregnancy, labor, birth and postpartum. The NBPC has found broad endorsement of its organizing statement; more than forty national and local groups have joined their efforts.

The statutory provision at issue in the case before this Court directly implicates not only consumer access to the Midwives Model of Care by the women and families of Missouri but also authorizes CPMs practice – both issues are central to the NBPC's mission and policy interests. For this reason, NBPC has joined with the other *amici* listed here to file this brief in support of the Appellants.

ARGUMENT

I. INCREASING ACCESS TO CERTIFIED PROFESSIONAL MIDWIVES ("CPMs") AND OUT-OF-HOSPITAL BIRTH IS BENEFICIAL TO MISSOURI'S CITIZENS.

A. Section 376.1753 RSMo limits its authorization to CPMs who are duly trained, qualified and certified.

Respondents and *amicus curiae* AMA suggest that the impact of § 376.1753 RSMo will be to legalize "lay" midwives – a characterization clearly designed to evoke images of incompetent and untrained practitioners. Respondents Brief at 56 (referring to CPMs authorized by the statute as "unlicensed, unregulated persons"); AMA Amicus Brief at 7,8,12,14,18. The provision in question, however, addresses only the legal status of Certified Professional Midwives (CPMs). This rigorous credential is established and administered by the North American Registry of Midwives ("NARM"), an international agency founded 20 years ago by the Midwives Alliance of North America ("MANA"). North American Registry of Midwives, *How to Become a Certified Professional Midwife* (2005) (herein referred to as "NARM Standards"). In no way does § 376.1753 RSMo permit or authorize the practice of "lay" midwives or "untrained" midwives, contrary to what *amicus curiae* AMA asserts. AMA Amicus brief at p. 7,8 ("the midwife law's allowance of unregulated treatment of pregnancy and birth by those who are inadequately trained").

CPM certification validates knowledge, skills and abilities vital to high quality, professional midwifery practice. NARM works to define and establish standards for international certification with reference to national certifying standards formulated by the National Organization for Competency Assurance (NOCA). The requirements for CPM certification include didactic training and clinical internship, as well as passage of a national certification exam. Qualifications also require recertification every three years, a process that includes continuing education and mandatory peer review. Finally, the CPM is the only credential (medical or midwifery) that requires training and experience in attending out-of-hospital births. NARM standards, at 11.

NARM certification for CPMs is psychometrically-sound, and requires: (1) a rigorous educational and training process, averaging three to five years to complete; (2) verification of knowledge, skills and experience, including successful completion of a national board exam; (3) a clinical skills assessment; and, (4) clinical training in out-of-hospital settings, such as the patient's home or a freestanding birth center. This training prepares CPMs to: provide prenatal care; attend women in childbirth; screen potential clients to determine if they are appropriate candidates for out-of-hospital birth; assess and address complications while supporting the process of normal birth; and, develop a practical plan for transferring the mother to a medical setting, as needed. CPMs are trained to provide emergency care and to resuscitate the newborn, if necessary. CPMs also must have current Cardio-Pulmonary Resuscitation Certification – Adult Resuscitation and Infant or Neonatal Resuscitation Certification – in order to maintain their credential.

NARM's CPM credential has received accreditation by the National Commission for Certifying Agencies (NCCA), the accrediting arm of the National Organization for Competency Assurance (NOCA). On behalf of NOCA, NCCA accredits more than 200 professional credentials, including those for nurse-midwives, nurse-anesthetists, nurse practitioners, and critical care nurses, and their accreditation assures that the CPM credential meets rigorous standards. NOCA is the organization that is specifically referenced in § 376.1753 RSMo. *See*, http://www.noca.org/Resources/NCCAAccreditation/tabid/82/Default.aspx (last accessed February 4, 2008).

B. Missouri followed the wisdom of a growing number of states in recognizing the benefit of authorizing CPMs, who provide safe and high quality care, to practice.

The Missouri legislature is not alone in its wisdom in passing §376.1753 RSMo authorizing CPMs to practice. Nearly half of all states (twenty-two) have already recognized the safe and high quality of care provided by CPMs by similarly authorizing their practice. Midwives Alliance of North America, *Direct-Entry Midwifery State-by-State Legal Status* (2007), available at: http://www.mana.org/statechart.html (last

accessed February 17, 2008) (herein referred to as "MANA State Chart").[1] The legislature in each of those states found the CPM credential valuable as the basis for licensing or otherwise regulating midwifery practice. CPM licensure laws were recently enacted in Utah, Virginia and Wisconsin,[2] and bills to provide for such licensure are currently under consideration in several other states. Furthermore, in nine states – Alaska, Arizona, California, Florida, New Hampshire, New Mexico, Oregon, South Carolina, and Washington – CPMs receive Medicaid reimbursement for their services.[3] *Id*. Finally, while *amicus curiae* AMA argue that legalizing CPMs is dangerous to women and babies, at 7, this argument is specious considering that none of the twenty-two states has ever repealed its statute authorizing CPM practices state.

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[1] Those states are: Alaska, Arkansas, Arizona, California, Colorado, Florida, Georgia, Louisiana, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, New York, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia and Washington.

[2] Utah Code Ann. § 68-77-101, *et seq.* (Direct Entry Midwifery Practice Act); Utah Admin. Code R. 156-77 (Rules); Va. Code Ann. § 54.1-2957.7, *et seq.*; Wis. State. Ann. § 440.9805, *et seq.*

[3] In addition, the Veteran's Administration recognizes study for the CPM credential as reimbursable under the GI Bill for qualified veterans and their dependants. Department of Veteran Affair, Education Benefits, available at: http://www.gibill.va.gov/Education/LCweb/vieworg.asp?prev=get (last accessed February 17, 2008).

C. Section 376.1753 RSMo will permit CPMs to provide high quality, cost-effective care that will benefit Missouri's citizens and fill some significant gaps in the state health care system.

Not only does §376.1753 RSMo authorize, and thus permit, a group of highly skilled practitioners to provide their services to citizens of Missouri, but also it has the potential to provide a significant economic benefit to the state. Washington State recently sponsored a cost-benefit analysis of the program and the services provided by the licensed midwives. Health Management Associates, *Midwifery Licensure and Discipline Program in Washington State: Economic Costs and Benefits* (2007). The analysis estimated the cost savings to the health care system to be $2.7 million in one year and direct savings for the public sector were nearly $500,000. *Id*. at 1. The analysis noted that one-on-one labor support, integral to midwifery practice in out-of-hospital settings, has been shown to lower cesarean section rates and reduce the need for anesthesia, both of which can lead to complications and more interventions, and thus, require costly hospitalization. *Id*. at 10. In addition to significant cost savings, avoiding unnecessary medical interventions exposes the mother and infant to fewer medical risks.

II. CERTIFIED PROFESSIONAL MIDWIVES PROVIDE HIGH QUALITY, SAFE CARE TO PREGNANT AND BIRTHING WOMEN THAT DOES NOT POSE SUBSTANTIAL RISKS TO THE HEALTH AND WELFARE OF MISSOURI'S CITIZENS.

A. Home birth among low-risk women attended by CPMs does not jeopardize the health of mothers or infants, is authorized in 22 states, and is supported by many highly regarded international and professional organizations.

Contrary to the AMA's assertion, birth need not, indeed should not, be treated as a disease or an accident waiting to happen. Amicus Brief at 7,8. Childbirth is a normal physiological process. The World Health Organization ("WHO") concluded that the vast majority of births are normal[4] and that at the start of labor 70-80% of women are at low risk for complications. World Health Organization, *Care in Normal Birth: a Practical Guide*, at 7 (1996), available at: http://www.who.int/reproductive-health/publications/MSM_96_24/care_in_normal_birth_practical_guide.pdf (last accessed February 15, 2008) (herein referred to as "*Care in Normal Birth*").

[4] WHO defines normal birth as: "spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth mother and infant are in good condition." *Care in Normal Birth* at 7.

The medicalization of childbirth,[5] reflected by current hospital birth practice, has failed to make a relatively safe process safer. In fact, the United States ranks near the bottom of developed countries in terms of maternal and neonatal mortality. Save the Children, *Mother's Index* (2007) (United States ranks 26th out of 41 developed countries overall, 21st for maternal and 30th for infant mortality). Further, evidence demonstrates that current practices have led to increasing interventions, many of which are unnecessary. For example, the rate of cesarean section was 29.1% in 2005 and rose to 31.15 in 2006, a record high, even among low-risk women. Fay Menacker, *Trends in Cesarean Rates for First Births and Repeat Cesarean Rates for Low-Risk Women: United States 1990-2003*, 54 Nat'l Vital Statistics Rep. 4, at 9 (2005); Brady E. Hamilton, Joyce A. Martin, Stephanie J. Ventura, *Births: Preliminary Data for 2006*, 56 Nat'l Vital Statistics Rep., at 1 (2007). While rates continue to increase, this rise has not been explained by any associated health differences in pregnant women (compared to countries with lower cesarean rates) or justified by improved health outcomes.[6] Robert

[5] Childbirth is not inherently a "problem" needing medical "treatment," even if complications arise that require medical intervention. Its medicalization is often criticized as creating dependency on the medical system and infringing pregnant women's autonomy. D. Gould, *Normal labour: a concept analysis*, 31 J. ADVANCED NURSING 418 (2000). *See also, Care in Normal Birth*, *generally*.

[6] The WHO has stated that the optimal level of cesarean section is between 10 and 15%, and that where rates are either lower or higher the mother and child are exposed to

M. Silver, et al. *Maternal Morbidity Associated With Multiple Repeat Cesarean Deliveries*, 107 Obstetrics & Gynecology 1226 (2006); H. Cahill, *Male Appropriation and Medicalisation of Childbirth: An Historical Analysis*, 33 J. Advanced Nursing 334–42 (2000).

Moreover, routine practices and interventions – including episiotomies, continuous electronic fetal monitoring, elective induction and augmentation of labor, and epidural anesthesia – have not always been evidence-based, and following their implementation have been assessed as ineffective and/or harmful. Routine use of these interventions have the potential to require additional intervention and expose the mother and neonate to medical risks. M. Enkin, *A Guide to Effective Care in Pregnancy and Childbirth*, Synopsis & Tables 1-6 (Oxford University Press) (2000); J. Goldberg , D. Holtz, T. Hyslop, J.E. Tolosa, *Has the Use of Routine Episiotomy Decreased? Examination of episiotomy rates from 1983 to 2000*, 99 Obstetrics & Gynecology 395, at 395 (2002) (describes problems associated with episiotomies); Henci Goer, *Elective Induction of*

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unnecessary and avoidable risk of either mortality or morbidity. World Health Organization, *Appropriate Technology for Birth*, 2 LANCET 436–437 (1985). Cesarean sections are associated with a high risk of maternal mortality, hysterectomy, injury to the urinary tract, abdominal pain, neonatal respiratory morbidity, fetal death, placenta previa, and uterine rupture in future pregnancies. Jose Belizan, Fernando Althabe, Maria Luisa Cafferata, *Health Consequences of Increasing Cesarean Section Rates*, 18 EPIDEMIOLOGY 485-6 (2007).

Labor (2002) available at: http://hencigoer.com/articles/elective_induction (last accessed February 17, 2008) (describes problems associated with induction).

Thus, rather than demonstrating childbirth's inherent dangers and the need for hospitalization to prevent mortality and morbidity, as the AMA urges the Court, AMA Amicus Brief at 7-10, current obstetric practice and resulting outcomes casts doubt on the relative safety of hospital birth practices or at least on their prudence and effectiveness.

As an alternative, CPMs offer a safe birthing option to women who want to avoid unnecessary interventions during childbirth. Studies have demonstrated that CPMs successfully and safely support normal birth with very low rates of transfer for emergency medical interventions, including minimal rates of cesarean section. O. Olsen & M.D. Jewell, *Home Versus Hospital Birth (Cochrane Review)*, 2 The Cochrane Library (2006), available at http://www.cochrane.org/reviews/en/ab000352.html (last accessed February 17, 2008); K.C. Johnson & B. Daviss, *Outcomes of Planned Births With Certified Professional Midwives: Large Prospective Study in North America*, 330 Br. Med. J. 1416 (2005); P.A. Janssen, K.L. Shoo, E.M. Ryan, D.J. Etches, D.F. Farquharson, D. Peacock, D., et al, *Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia*, 66 Canadian Med.l Ass'n J. 315 (2002); C. Sakala, *Midwifery Care and Out-of-Hospital Birth Settings: How do They Reduce Unnecessary Cesarean Section Births?*, 37 Social Science & Medicine 1233-50 (1993). Moreover, CPM practice does not employ drugs to induce or augment

labor in normal birth.[7] Henci Goer, *The Thinking Woman's Guide to a Better Birth* (1999), at 49-71, 125-148 (The Berkley Publishing Group) (1999). Avoiding myriad medical interventions – as is the case in the vast majority of births attended by CPMs – significantly reduces the exposure of mothers and infants to the attendant risk of complications.

Considering the wealth of information demonstrating the safety of home birth attended by trained professionals such as CPMs, the authorization of CPM practice in the State of Missouri is sound public policy. Moreover, the court should not overlook the fact that numerous other states, *see* Brief at 7, *supra*, countries, and international and professional groups support this practice. World Health Organization, *Care in Normal Birth*; Royal College of Obstetricians & Gynecologists & the Royal College of Midwives, *Joint Statement No. 2., Home Birth* (2006), American Public Health Association, Governing Council, *Increasing Access to Out-of-Hospital Maternity Care Services Through State-Regulated and Nationally Certified Direct-Entry Midwives* (2001); College of Physicians and Surgeons of Ontario & the Society of Obstetricians and Gynaecologists of Canada, *Statement on Home Birth* (1994). In fact, in many countries, midwifery care is integrated into the maternity care, even if in some countries the percentage of home birth is nearly as low as it is in the United States. W. Christianes

[7] There are many other midwifery practices that encourage normal birth, such as by providing thorough prenatal care and counseling, by encouraging the woman to move and have food during labor, and by providing emotional support and encouragement.

& P. Bracke, *Place of Birth and Satisfaction with Childbirth in Belgium and the Netherlands*, 10 Midwifery 1016 (2007); C. Benoit, S. Wrede, I. Bourgeault, et al., *Understanding the Social Organization of Maternity Care Services: Midwifery as a Touchstone*, 27 Sociology of Health & Illness 209-232 (2005); *Care in Normal Birth*.

B. The AMA's criticisms of the safety of home birth attended by CPMs are unsupportable.

The AMA's claim that childbirths "require the expertise of a physician and/or a certified nurse-midwife, as well as the technological and staffing resources of a hospital" is unsupportable. AMA Amicus Brief at 7. This claim has never been established by published research. In fact, the WHO criticizes this approach as harmful to women:

> This widespread notion led obstetricians in many countries to conclude that care during normal childbirth should be similar to the care in complicated deliveries. This concept has several disadvantages: it has the potential to turn a normal physiological event into a medical procedure; it interferes with the freedom of women to experience the birth of their children in their own way, in the place of their own choice; it leads to unnecessary interventions; and, because of the need for economies of scale, its application requires a concentration of large numbers of labouring [*sic*] women in technically well-equipped hospitals with the concomitant costs. *Care in Normal Birth* at 2.

The AMA goes on to assert, at 8, that the hospital setting is critical to ensuring the safety of mothers and their babies because "[m]ost maternal deaths and serious

complications occur during labor and delivery," yet this assertion is not supported by any evidence provided by *amicus curiae*. The cited study actually demonstrates that while nearly 100% of pregnant women give birth in hospitals, 1/3 of them experienced morbidity in childbirth in the 1990's, a time when there were lower rates of interventions than at present. I. Danel, et al., *Magnitude of Maternal Morbidity During Labor and Delivery: Untied States, 1993-1997*, 93 Amer. J. Pub. Health 631 (2003). Far from calling into question the value and safety of CPMs generally, or home birth specifically, this study acknowledges that, when giving birth in hospitals, women face risks of illness and injury. The study does not assess the cause of morbidity or what could be done to reduce it. However, at least some of the morbidity noted in this study clearly is caused by practices and interventions that are routinely used in hospital births, and the authors of that study go on to state:

> Primary prevention is possible for some of these complications, including certain causes of hemorrhage, infection, and complications of obstructed labor. In the case of complications that cannot be prevented, the goal is appropriate management to keep them from becoming severe or life threatening. Danel at 633.

CPMs not only avoid unnecessary interventions that can cause morbidity, but they also are well-trained to provide primary prevention and management of complications, including transfer to a tertiary care facility when necessary. NARM Standards, 1,2,4. That maternal morbidity during labor may be a common event does not provide a basis for concluding that hospitalizing all laboring women is the solution.

The AMA claims that childbirth "**often** presents **sudden** health crises" is not supported by the evidence. Amicus brief at 7 (emphasis added). It may be that obstetricians see frequent, sudden "health crises" in their patients, but these may be due to the many ways that hospital protocols interfere with the normal process of birth and the many interventions experienced by women birthing in a hospital. Declercq ER, Sakala C, Corry MP, Applebaum S. *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences* (2006) (survey found less than 1% of mothers gave birth without at least one medical intervention); Maternity Center Association, *Listening to Mothers: Report of the First National U.S. Survey of Women's Childbearing Experiences* (2002). However, results of a prospective study of all births attended by CPMs in 2000 demonstrate that serious health crises do not occur either often or suddenly in planned home births attended by CPMs. K.C. Johnson & B. Daviss, *Outcomes of Planned Births With Certified Professional Midwives: Large Prospective Study in North America,* 330 Br. Med. J. 1416, 1418 (2005) (referred to as "CPM2000"). In that study, 12% of women planning to birth at home were transferred to the hospital. *Id.* More than 90% of such transfers occurred before delivery and were not characterized as "emergency" transfers. *Id.* Rather, most of these transfers were for failure to progress, a desire for pain relief or exhaustion. *Id.* Less than 1% of mothers were transferred to hospital during labor or postpartum under circumstances that would be considered emergencies. *Id*.

AMA's state that: "midwives' claims that pre-screening eliminates high-risk pregnancies from their care are misguided"; this is a baseless opinion. AMA Amicus

Brief at 8. The outcomes presented in CPM2000 demonstrate that CPMs adequately screen and do not take on women with high-risk pregnancies. Johnson & Daviss, at 1417. Furthermore, if appropriate screening were not taking place, it is doubtful that 22 states would continue to license these midwives.

Contrary to the AMA's unsupported assertions about home birth safety, the "clear preponderance of medical literature" suggests that home births, when they are planned and attended by a well-trained professional midwife, in fact, may be less dangerous for mother and baby than giving birth in a standard hospital, as described in more detail above. *See* Brief at 13-4, *supra*. Among the myriad studies on home birth, the only study cited by the AMA to support its assertion that home birth is risky is the only one to have found otherwise, yet this study has serious design flaws that undermine its validity. J.W.Y. Pang, et al., Outcomes of Planned Home Births in Washington State: 1989-1996, 100 Obstetrics & Gynecology 253 (2002). Criticisms are: that unplanned home births were included; planned home birth with unqualified attendants were included; preterm births were included; study groups are incomparable; home births should have been matched to those in a hospital in the same area; and outcomes were poorly defined and not all relevant outcomes were included. Henci Goer, *When Research is Flawed: The Safety of Home Birth* (2004), available at: http://www.lamaze.org/Research/WhenResearchisFlawed/homebirth/tabid/172/Default.aspx. The authors themselves state: "caution should be used when interpreting the results for these outcomes." Pang, at 258.

The AMA asserts that neonatal mortality was higher for both planned and unplanned home births in Missouri citing a study by Schramm, et al. Amicus Brief at 9; W.F. Schramm, D.E. Barnes, R.N. & J.M. Bakewell, *Neonatal Mortality in Missouri Home Births, 1978-1984*, 77 Amer. J. Pub. Health 930 (1987). This study was conducted on birth data from 1978-1984, well before the CPM credential was created. Therefore, the results are not relevant to the issue of outcomes of births attended by CPMs. AMA also fail to mention that in that study births to attended with "lower level of training" accounted for almost all of the greater than expected number of neonatal deaths among planned home births, compared to expected outcomes for hospital births. Schramm, at 930. The "higher level of training" group had slightly less than the expected number of neonatal deaths. Outcomes for unplanned home births or those attended by "lesser trained" midwives, as noted by the AMA brief, at 9, are not relevant to assessing the safety of planned home birth attended by CPMs.

Disturbingly, the AMA brief relies heavily on an article that reflects one woman's experience. Amicus Brief at 9,10; Michelle L. Crossley, *Childbirth, Complications, and the Illusion of "Choice": A Case Study*, 17 Feminism & Psycology 543 (2007). Surely, the AMA does not recommend that either public policy or medical care be based on anecdotal evidence, published in a non-medical journal, no matter how compelling. Regardless of such wisdom, the AMA seriously misrepresents Crossley's paper, which criticizes the medicalization of birth and the lack of counseling and choice women experience during labor and delivery in hospitals. *Id*. Crossley in no way claims, as the AMA suggests, that there is an "illusion of choice" during childbirth due to the "frequent

need for medical intervention to ensure safe delivery," and that rather women must accept that their choice is limited by this reality. AMA Brief at 10. The author describes her own maternity experience in England, and finds that "choice" and "freedom" are relative and that the social relationship with medical professionals is "irrevocably unequal." Crossley at 558, 559. Crossley's work in no way supports the AMA's assertion that home births are an idealistic fantasy and that its advocates are "uncritical." Amicus Brief at 10. Her work advocates alternative approaches to hospital births attended by physicians, such as home births attended by CPMs, and underscores the benefit of such alternatives.

Finally, the AMA asserts that Johnson and Daviss' study (CPM2000) is seriously flawed, and therefore, does not support the conclusion that such home birth is safe. Amicus Brief at 10,11; *see*, *generally*, Johnson & Daviss. The observational data from this prospective cohort study undoubtedly supports the safety of home birth, despite the limitations highlighted by the authors. Johnson & Daviss, at 5,6. To this end, the AMA's criticisms are unconvincing, as they neither undermine the validity of the study's results nor disprove its authors' conclusions about the safety of home birth.

First, the fact that hospital transfers are not included as medical interventions is irrelevant to assessing the safety of home birth alone or relative to hospital birth. Hospital transfer by itself is not a "medical" intervention. Further, as stated earlier, at 16-7, *supra*, the vast majority of transfers were before delivery, usually for failure to progress, pain relief or exhaustion.

Second, the AMA characterizes the authors as "biased home birth advocates." Amicus Brief at 11. This *ad hominem* attack is irrelevant to assessing the quality and conclusions of the study. Would the AMA disqualify a study on hospital birth authored by an obstetrician? The paper was published in the peer-reviewed *British Medical Journal*, one of the foremost medical journals in the world. The process of peer-review is designed to provide a neutral assessment of research publications, including of its design, analysis and conclusions.

The only one of the AMA's assertions that warrants consideration is that the study was not comparative. Undeniably, a randomized-controlled study is the "gold-standard" in research, but not all research questions are fit for study by this method. Experts in the field of obstetrics and gynecology agree that "[r]andomised controlled trials to assess the safety of home birth are currently not feasible," and that observational data provide a rational basis for assessing their safety. Royal College of Obstetricians & Gynaecologists and Royal College of Midwives, *Joint Statement No. 2, Home Births*, (2007); Saraswathi Vedam, *Home Birth Versus Hospital Birth: Questioning the Quality of the Evidence on Safety*, 30 Birth 57 (2003).

Additionally, Johnson and Daviss have since prepared an analysis that compares the neonatal mortality observed in their study and the neonatal mortality rate for U.S. hospital births among Hispanic white women of 37 or more weeks' gestation in 2004. *Risks Similar in Careful Comparison of the CPM2000 and the 2004 U.S. Neonatal Mortality among Term Births to non-Hispanic White Women* (2004), available at: http://www.understandingbirthbetter.com/section.php?ID=31&Lang=En&Nav=Section

(last accessed on February 15, 2008). Adjustments were made to the data in order to ensure the groups were comparable, as far as possible, including the exclusion of intra-partum deaths and deaths involving lethal congenital defects. The adjusted neonatal death rate was less than one death per 1000, both among the women in the CPM2000 study and among those experiencing hospital births in the U.S. in 2004.

Their assessment of the safety of home births attended by CPMs following this analysis was the same as that in their paper: neonatal mortality among low-risk women in North American using CPMs is similar to that for low-risk women in hospitals in the U.S., and intervention rates are much lower.

III. THE EMERGENCY MEDICAL TRANSFER AND ACTIVE LABOR ACT IS NOT APPLICABLE TO THE PRESENT CASE.

The reference by *amicus curiae* AMA to EMTALA, at 13,14, demonstrates the extent to which they are grasping at straws. As the AMA well knows, EMTALA does not, and was never intended to, address the safety or scope of practice of particular practitioners or to recommend that birth should take place in hospitals. Instead, EMTALA – also known as the "Patient Anti-Dumping Act" – was enacted in response to wide-spread reports that certain hospitals were refusing care to patients needing immediate attention who had presented but who had no way to pay for care.[8] Those

[8] "The Emergency Act was passed in 1986 amid growing concern over the availability of emergency health care services to the poor and uninsured. The statute was designed principally to address the problem of "patient dumping," whereby hospital emergency

patients were either turned away at the hospital door, or transported to other hospitals (without the receiving hospitals' knowledge or consent) – leaving the patients worse off than if they had gone elsewhere in the first place.

EMTALA by its terms does not deem labor itself an emergency medical condition; rather it properly recognizes that a woman *whose birth is imminent* needs immediate attention and that the Act's anti-dumping provisions should apply in such circumstances. The Act does not send a signal that birth is dangerous; it simply requires that hospitals not put financial concerns above the well-being of patients.

We also take issue with the AMA's statement, at 13, made almost in passing, that emergency transfers from home to hospital become hospital statistics, thereby masking the truerisks of home birth. First we note, at 17, that not all transfers from home to hospital are emergencies. But more importantly, as discussed elsewhere in this brief, we note that all reputable studies of home birth include hospital transports *among the home birth data*. Even so, every one of these studies except one demonstrates that home birth is as safe or safer than hospital birth. *See*, Brief at 12-3, *supra*.

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rooms deny uninsured patients the same treatment provided paying patients, either by refusing care outright or by transferring uninsured patients to other facilities." *Gatewood v. Washington Healthcare Corp.*, 290 U.S. App. D.C. 31, 933 F.2d 1037 (D.C. Cir. 1991).

IV. THE MEDICAL ASSOCIATIONS' OPPOSITION TO HB 818 HAS LESS TO DO WITH THE MISSOURI CONSITUTION OR THE SAFETY OF CHILDBIRTH, AND MORE TO DO WITH PROTECTING THE PHYSICIANS' PROFESSIONAL FRANCHISE.

Over a century ago, the leadership of organized medicine called for the end of midwifery and proceeded to accomplish that goal with a campaign to eliminate midwifery that lasted for several decades. Judith Pence-Rooks, *Midwifery and Childbirth in America*, 22 (Temple University Press) (1997). The developing profession of obstetrics benefited from the elimination of midwifery. *Id.* at 24. In that campaign, physicians used arguments similar to the ones presented here: midwives are untrained and incompetent, pregnancy is dangerous and complicated, and midwifery stood in the way of progress. *Id*.

At that time, a leading obstetrician stated: "If an uneducated woman of the lowest classes may practice obstetrics, is instructed by doctors and licensed by the State, it certainly must require little knowledge and skill – surely it cannot belong to the science and art of medicine." *Id*. Several decades later, Dr. Nicholas Eastman emphasized that "to the vast majority of obstetricians the very word midwife is anathema." *Id.* at 41. This attitude toward midwifery constrained its development in the United States much longer than in other industrialized nations like France and England, where midwives today attend the majority of births, and where maternal and infant mortality are among the lowest in the world. *Id.* at 17; Save the Children, *Mother's Index* (2007).

Nonetheless, economic and geographic gaps in access to physicians services, as well as a strong preference among some consumers for holistic maternity care minimizing technological interventions, has resulted in a continuing and growing demand for midwifery childbirth services. *Id.* at 51. The professions of Certified Nurse-Midwifery and CPM have developed, albeit slowly, as a result. *See, generally,* Pence-Rooks, *supra.* The statute legalizing CPMs, which the Medical Associations seek to overturn, is an example of "interprofessional intersection" resulting from the overlapping scope of practice between physicians and midwives. Susan Baker, *The Nurse Practitioner in Malpractice Actions: Standard of Care and the Theory of Liability*, 2 HEALTH MATRIX 325 (1992). In every state where such intersections have resulted in physician-midwife, physician-nurse, or physician-chiropractor conflict, organized medicine has adopted the public role of a benign protector of patients from professional groups characterized as less-educated or incompetent would-be providers of "medical" care. *See id.* But, as Professor Barbara Safriet points out in the *Yale Journal of Regulation*, the legislature is the ultimate determiner of which scope of practice will be legally recognized for any particular health profession. *See, generally,* Barbara J. Safriet, *Closing the Gap Between Can and May: A Primer for Policymakers*, 19 YALE J. ON REG. 301 (2002).

Historically, the practice of medicine was so broadly defined that physicians came to view all health care practice as their exclusive domain, even though other health care professionals have also been educated and licensed for particular scopes of practice. Pence-Rooks, *supra,* at 333-335*;* Safriet, *supra,* at 305-308. Yet as Baker explains,

"[t]he practice of medicine is not stagnant. As it grows and becomes capable of performing more complex tasks, some tasks and processes … come to be viewed less exclusively as the domain of medicine and in fact can often be better performed by other health care professionals with different training." Baker, *supra*, at 341 note 82. Notwithstanding the recognition by many authorities that professionals other than physicians can deliver health care as well or better than physicians in certain circumstances, the organized medical community will have none of it - making their dire warnings about midwifery practice unsurprising. Indeed, denigrating the competence and scope of practice of other health professionals is central to the AMA's political agenda. Organized medicine routinely opposes legislation that would permit other health professionals to practice to the full extent of their certified scope of practice. *See, generally*, Safriet, *supra*. In fact, the medical profession recently institutionalized its opposition efforts; in November 2005, the AMA House of Delegates voted to combine with several other physician groups to oppose attempts by other health professionals to obtain autonomous licensure or expand their scope of practice. This initiative is called the Scope of Practice Partnership (SOPP), and its efforts are ongoing. American Medical Association, *Resolution 814 – Limited Licensure Health Care Provider Training & Certification Standards* (2005); see also, American Medical Association, Motion on *Resolution 814* (2005). Indeed, they are reflected in the case at hand.

CONCLUSION

Mo. Rev. Stat. §376.1753, authorizing the safe, high-quality care provided to pregnant women, is sound public policy, with numerous benefits to Missouri's citizens. Therefore, Amici urge the Court to overturn the decision of the Circuit Court of Cole Country and to enter an order holding the statute valid.

Respectfully submitted,

MARY J. BROWNING LLC

By: _____

Mary J. Browning, #34633
214 Cherry Street
Jefferson City, MO 65101
Telephone No.: (573) 893-4523
Facsimile No.: (573) 893-4591
E-mail: mary@maryjbrowninglaw.com

Attorney for Amici

CERTIFICATE OF COMPLIANCE

The undersigned hereby certify that this brief contains the information required by Mo. Sup. Ct. R. 55.03, complies with Mo. Sup. Ct. R.84.06(b) and contains 7,351 words total and 7,201 words, excluding the parts of the brief exempted. The undersigned also hereby certifies that the brief has been prepared in proportionately-spaced typeface using Microsoft Word in 13 pt. Times New Roman Font, and includes a compact disk in Microsoft Word format, which has been scanned for viruses and is virus free.

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Counsel for *Amici*

CERTIFICATE OF SERVICE

The undersigned hereby certifies that two accurate copies of the foregoing brief and a disk containing the foregoing brief were sent via U.S. Mail, this 19th day of February, 2008, to:

Harvey M. Tettlebaum
Robert L. Hess II
Husch & Eppenberger
235 East High Street, Suite 200
Jefferson City, MO 65102

ATTORNEY FOR RESPONDENTS

Jeffery S. Howell
113 Madison Street
Jefferson City, MO 65102

ATTORNEY FOR RESPONDENT MISSOURI STATE MEDICAL ASSOCIATION

Jeremiah W. (Jay) Nixon
John K. McManus
Supreme Court Building
Post Office Box 899
Jefferson City, MO 65102

ATTORNEYS FOR APPELLANT STATE OF MISSOURI

James B. Deutsch
Marc H. Ellinger
Jane A. Smith
Thomas W. Rynard
Blitz, Bardgett, & Deutsch, L.C.
308 East High Street, Suite 300
Jefferson City, MO 65102

ATTORNEY FOR APPELLANTS FRIENDS OF MISSOURI MIDWIVES, ET AL.

Johnny K. Richardson
Brydon, Swearengen & England, P.C.
The Hammond Building
312 East Capitol Avenue
Jefferson City, MO 65102

Leonard A. Nelson
Barat S. McClain
American Medical Association
515 North State Street
Chicago, IL 60610

ATTORNEYS FOR AMICUS CURIAE AMERICAN MEDICAL ASSOCIATION

_____
Counsel for *Amici*