REDEFINING BIRTH: THE LEGAL HISTORY OF MIDWIFERY IN COLORADO AND FORGING A PATH TOWARD PERINATAL CARE THAT PRIORITIZES HEALTH AND WELLNESS FOR ALL

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ABSTRACT

A century ago, medicine, in collaboration with the law, redefined birth as a medical event. This Article illustrates the resulting consequences of medicine's coopting of birth for its own benefit, and explains what opportunities exist to correct these consequences. Although this Article uses the history of childbirth in Colorado to illustrate this issue, the Colorado experience is generally reflective of the rest of the United States. To counteract the negative effects of the medicalization of childbirth, certain core principles must be instilled in legislation aimed to protect the interests of birthing people: midwifery should be independent from medical care and pregnant people must retain the authority to make decisions about their own care. Too often, laws are overly restrictive on midwives as a result of the way medicine and the law define risk, compromising midwifery's effectiveness, despite evidence of the midwifery model's benefits. This Article discusses how current legislation is designed, with intersectionality in mind, to reframe the misogyny baked into the current sociopolitical landscape of health care, and the aspects of those pieces of legislation that would be beneficial to retain moving forward. Finally, this Article advocates for structural change that

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addresses the long-lasting and still-existing effects of racism in the medical and legal fields to create an equitable system of care for all birthing people.

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INTRODUCTION

This Article outlines how medicine, in collusion with the law, set out to redefine birth as a medical event, what the resulting consequences of such medicalization have been, and what opportunities for course correction exist and are being leveraged today. This Article focuses on Colorado, but the same general history could be told across the country. About 100 years ago, the field of medicine defined and eventually replaced midwifery, and in doing so, also defined birth and birthing people as within the exclusive purview of medicine.[1] As a result, the idea of birth as a normal, physiological process that

1. *See* AMANDA CARSON BANKS, BIRTH CHAIRS, MIDWIVES, AND MEDICINE 33–34 (1999).

is usually best addressed by families and midwives, was legally replaced with the idea of birth as a medical event. This "fact" was written into the law regulating, eliminating, and eventually re-regulating midwifery.

It is a major misperception that childbirth is medicalized today because medicine is the natural way to manage the inherent risks and best maximize the outcomes, or that medicine is part of our evolution as humans. "While a highly medicalized approach to birth is dominant in the United States, its prevalence is not explained by superior outcomes."[2] Medically regulated childbirth is not "natural," and its consequences come with risks and costs that are starting to be measured in current health outcome data and policy analysis.[3]

The chronological history of medicalized childbirth is told in four parts: (1) childbirth improved medicine (and not the other way around); (2) funneling birth into the hospital; (3) eliminating families and the legal medicalization of birth; and (4) legal risk and regulation. Part I of this Article explains the history of childbirth and midwifery in Colorado spanning from before statehood through the turn of the twentieth century. Part II outlines the history of the mid-twentieth century until midwifery was legally eliminated in 1976. Part III describes the organizing efforts of midwives in the eighties and nineties and how a Colorado Supreme Court case brought the medicalization of childbirth to its zenith.[4] Then, Part IV goes on to explain how midwifery was again legalized, but how the conflict between medicine and birth remained written into the law. Finally, Part V of this Article explains how the professionalization of midwifery challenges the medical definition of birth in Colorado. This Part also highlights efforts to change the law and suggests opportunities for continued improvement. The underlying assumption is that

2. Alexa Richardson, *Developments in the Law—The Legal Infrastructure of Childbirth*, 134 HARV. L. REV. 2209, 2211 (2021).

3. *Id*. at 2211–12.

4. *See* People v. Rosburg, 805 P.2d 432 (Colo. 1991).

birth matters. It is consequential not only because it is how everyone gets here, but also because it is a significant organizing principle for societies and life. To appreciate the consequences of this transformation, the medical and midwifery definitions of birth must be compared.[5] Given the changing landscape of constitutional law with regard to reproduction as indicated by the forthcoming Supreme Court decision in *Dobbs v. Jackson Women's Health*, this analysis is also an important part of building a more durable legal foundation for reproductive justice.

The following excerpt from *Evidence Based Maternity Care: What It Is and What It Can Achieve* describes, in the language of medicine, the costs of overriding midwifery's definition of birth with medicine's:

> Although most childbearing women and newborns in the United States are healthy and at low risk for complications, national surveys reveal that essentially all women who give birth in U.S. hospitals experience high rates of interventions with risks of adverse effects. Optimal care avoids when possible interventions with increased risk for harm. This can be accomplished by supporting

5. *See, e.g.*, ROBBIE E. DAVIS-FLOYD, BIRTH AS AN AMERICAN RITE OF PASSAGE 51–59, 158–62 (2d ed. 2003); JUDITH PENCE ROOKS, MIDWIFERY AND CHILDBIRTH IN AMERICA 25 (1997); CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE (2008), https://www.milbank.org/wp-content/uploads/2016/04/0809MaternityCare.pdf; RICKIE SOLINGER, PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA (2005); Marian F. MacDorman, Fay Menacker & Eugene Declercq, *Trends and Characteristics of Home and Other Out-of-Hospital Births in the United States, 1990–2006*, NAT'L VITAL STAT. REPS., Mar. 3, 2010, http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_11.pdf; Farah Diaz-Tello, *Invisible Wounds: Obstetric Violence in the United States*, 24 REPROD. HEALTH MATTERS 56 (2016); Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, 38 MED. ANTHROPOLOGY 560 (2018); THE NAT'L ACADS. OF SCIS, ENG'G, & MED., BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE (Susan C. Scrimshaw & Emily P. Backes eds., 2020) [hereinafter BIRTH SETTINGS IN AMERICA], https://www.ncbi.nlm.nih.gov/books/n/nap25636/pdf/; Jennifer Block, *The Criminalization of the American Midwife*, LONGREADS (Mar. 2020), https://longreads.com/2020/03/10/ criminalization-of-the-american-midwife/.

> physiologic childbirth and the innate, hormonally driven processes that developed through human evolution to facilitate the period from the onset of labor through birth of the baby, the establishment of breastfeeding, and the development of attachment . . . . With appropriate support and protection from interference, for example, laboring women can experience high levels of the endogenous pain-relieving opiate beta-endorphin and of endogenous oxytocin, which facilitates labor progress, initiates a pushing reflex, inhibits postpartum hemorrhage, and confers loving feelings . . . Such physiologic care is also much less costly . . . Burgeoning research on the developmental origins of health and disease clarifies that some early environmental and medical exposures are associated with adverse effects in childhood and in adulthood.[6]

This idea that birth is an innate physiological process that happens spontaneously and effectively, and confers benefits, but is also not a process that guarantees live-birth, is important not only scientifically but as a legal concept because it protects the autonomy and dignity of pregnant people and families. Without this legal concept, the bodies of people involved in the process are too easily swept into the control of the state as if pregnancy is something that can and should be controlled to promote a specific medically defined outcome.

6. SAKALA & CORRY, *supra* note 5, at 4.

I. CHILDBIRTH IMPROVED MEDICINE (AND NOT THE OTHER WAY AROUND)

Before Colorado was a state, it was inhabited for centuries by Indigenous people from tribes that English speakers have called the Ute, Arapaho, Cheyenne, Jicarilla Apache, Comanche, Pawnee, Osage, Kiowa, Comanche, and Sioux.[7] The Spanish were among the first settlers, inhabiting the Southern part of what is now Colorado since the early 1600s. Over the next couple hundred years, other settlers of various races and ethnicities began to reside in the area.[8] Until the mid-nineteenth century, childbirth in the First Nations was regulated by individual communities based on their cultural norms.[9] I like to imagine my paternal great-grandparents, who were born in what is now Southern Colorado. Even today there is not a hospital for miles—it's considered a "maternity care desert,"[10] and the arid and rocky terrain makes travel difficult. Though I do not know the details of how they were born, or what good maternity care looked like in their community of Indigenous/Spanish/Mexican/newly American families, they were certainly born at home and not in a hospital. By the mid-1800s there were likely around 20,000 to 30,000 people in the region, and a number of them were regularly giving birth.[11] This history is the backdrop for the transformation of birth in

7. *See* NATIVE LAND DIGIT., https://native-land.ca/ (last visited Apr. 13, 2022).

8. *Id.*

9. *See generally* JUDY BARRETT LITOFF, THE AMERICAN MIDWIFE DEBATE: A SOURCEBOOK ON ITS MODERN ORIGINS 13, 19 (1986). *See* Terry O'Driscoll, Lauren Payne, Len Kelly, Helen Cromarty, Natalie St. Pierre-Hansen & Carol Terry, *Traditional First Nations Birthing Practices: Interviews with Elders in Northwestern Ontario*, 33 J. OBSTETRICS & GYNAECOLOGY CAN. 24 (2011).

10. MARCH OF DIMES, NOWHERE TO GO: MATERNITY CARE DESERTS ACROSS THE U.S. 5 (2020) (describing "maternity care deserts . . . as counties in which access to maternity health care services is limited or absent, either through lack of services or barriers to a woman's ability to access that care").

11. *Urban and Rural Population: 1900–1990*, U.S. CENSUS BUREAU (Oct. 1995), https://www2.census.gov/programs-surveys/decennial/tables/1990/1990-urban-pop/urpop0090.txt [hereinafter *Urban and Rural Population*]. This is an estimation based on federal census data, as population data is limited prior to 1860 partly because the area known as Colorado had different jurisdictions, including tribes as well as land owned by Spain, Mexico, Texas, and France.

Colorado and a humbling reminder of our innate human capacity to reproduce without medicine.

In the 1860s, the advent of state-building and organized medicine in the Colorado region was a turning point in the medicalization of childbirth. The development of state and medical infrastructure went hand in hand. In 1860, about twenty physicians in Colorado started a medical society.[12] In 1861, the area became a United States territory.[13] In 1871, the Colorado Territorial Medical Society was formed and,[14] in 1876, Colorado became a state.[15] In the next twenty-five to forty years, white, European settlers built familiar infrastructure that modeled their idea of a state.[16] In 1881 and 1883, the University of Denver and the University of Colorado, respectively, started medical schools.[17] At the same time, the state began regulating the practice of medicine through a licensing system.[18] In 1894, Colorado became the second state in the nation to grant suffrage to women (following Wyoming) and in 1897, the Colorado State Bar Association was formed.[19] At one point there were four medical schools in Denver alone, evidencing the explosion in medical training that put more medical schools in the United States than anywhere in the world.[20] But this growth in medical training was more about the

12. *See* 1 HISTORY OF COLORADO 766 (Wilbur Fisk Stone ed., 1918).

13. *Id.* at 172.

14. *Id.* at 766.

15. *Id.* at 189. Notably, the medical society excluded women for the first ten years. *See id.* at 773; *see also* Kimberly Jensen, *The "Open Way of Opportunity": Colorado Women Physicians and World War I*, 27 W. HIST. Q. 327, 337 (1996).

16. *See generally* HISTORY OF COLORADO, *supra* note 12, at 190 (detailing the advancements Colorado made following statehood).

17. *See id.* at 603, 606, 611–12.

18. *See* Jensen, *supra* note 15, at 337–38 (noting that the licensing system required an "'objective' professional standard" and, as a result, the medical society could no longer bar women from participation).

19. HISTORY OF COLORADO, *supra* note 12, at 694–95; *Colorado Bar Association Quick Facts & Tip Sheet*, COLORADO BAR ASSOCIATION, https://www.cobar.org/About-the-CBA/Quick-Facts-About-the-CBA#9648473-founded (last visited May 3, 2022).

20. *See* 1 TOM SHERLOCK, COLORADO'S HEALTHCARE HERITAGE: A CHRONOLOGY OF THE NINETEENTH AND TWENTIETH CENTURIES 516 (2013).

development of a profession, a class of people, and a set of ideals, than an increase in knowledge or experience—especially when it came to childbirth.[21]

By the turn of the century, more and more physicians were attending women in labor, although mostly at home as the infrastructure of hospitals were not designed to accommodate birth.[22] However, "[a]s late as 1910, many medical school graduates began the practice of medicine having witnessed few or no births."[23] Despite this, midwives only attended 50% of births at the time.[24] Because so few physicians were knowledgeable about birth, decisions about quality were likely not to blame for the growing use of physicians as care providers. In fact, "[s]everal early twentieth-century studies revealed that maternal mortality rates were lowest in those localities reporting the highest percentage of midwife-attended births."[25] Many variables contributed to this change in the culture of birth, and while there was no single determining force, quality of care was not a strong determinant.

The culture of birth, like the culture in general, was in a state of flux. During the first decade of the twentieth century, Colorado's population grew from 539,000 to almost 800,000 people.[26] Conflict between the mining industry and unions culminated in substantial loss of life and the use of federal troops.[27] Only twenty-nine years after the Ute Indians were removed to reservations in Colorado, over 46,000 farms were operating, and the balance of urban and rural populations were shifting.[28]

21. HISTORY OF COLORADO, *supra* note 12 at 766; Judy Barrett Litoff, *An Enduring Tradition: American Midwives in the Twentieth Century*, *in* READINGS IN AMERICAN HEALTH CARE 223, 223 (William G. Rothstein ed. 1995).

22. Litoff, *supra* note 21, at 227.

23. *Id.* at 225.

24. *Id.*

25. *Id.*

26. *Urban and Rural Population*, *supra* note 11.

27. *See generally* KATHERINE L. CRAIG, CRAIG'S BRIEF HISTORY OF COLORADO 241 (1923).

28. HISTORY OF COLORADO, *supra* note 12, at 106–07.

While women in Colorado could vote, suffrage was being debated on the federal level and women were still excluded from full citizenship in many ways.[29] Women accounted for about 7% of the physicians in Colorado, which was above the national average.[30] This included Dr. Justina Ford, who was not allowed to practice in hospitals because she was a Black woman, leading her to start a clinic at her home in Denver's Five Points neighborhood.[31] In contrast to physicians, the vast majority of midwives were women. In the first decade of the century, midwifery was treated as a profession and considered a service to the community.[32] The reputation of midwifery benefited the health of the community but, as discussed in more detail below, damaged the prestige of the medical profession.[33]

In 1912, one of the leading obstetricians of the twentieth century, J. Whitridge Williams, published an article called "Medical Education and the Midwife Problem in the United States," outlining his plan to improve medical training and the status of obstetrics, which at the time was the least appreciated branch of medicine.[34] Midwives undermined the status of obstetrics because they were (mostly) women—many of them women of color or immigrants (who were often explicitly disparaged as such). Because their role in childbirth was so pervasive, it was hard to conceive of an upper class white man having a role, much less setting the terms.[35] The creation of the "midwife problem" gave doctors a way to bring childbirth into their purview. This coincided with the popular belief in eugenics, the idea that "defective genes" contributed to all sorts

29. *See* Jensen, *supra* note 15, at 328, 332.

30. *Id.* at 336.

31. Katie Kerwin McCrimmon, *Barred from Denver Hospitals, Black Woman Doc Practiced Medicine at Home and Delivered 7,000 Babies*, COLO. TIMES RECORDER (Feb. 19, 2021), https://coloradotimesrecorder.com/2021/02/black-woman-doc-practiced-medicine-at-home/34629/.

32. Patricia G. Tjaden, *Midwifery in Colorado: A Case Study of the Politics of Professionalization*, 10 QUALITATIVE SOCIO. 29, 32 (1987).

33. *See id.*

34. Litoff, *supra* note 21, at 225.

35. *Id.* at 224–25.

of physical and social ills, and that medical intervention like sterilization could relieve society of these ills.[36] Forced sterilization legislation was first advanced in 1921 by Dr. Minnie C.T. Love, a female physician who became a Colorado House Representative.[37]

Not only were strong lines drawn between classes of people, but those lines were reinforced through political power, with doctors like Dr. Love directly creating and informing laws and policies. This is the context for Dr. Williams' complaint that "the obstetrician should not be merely a man-midwife," and the efforts to develop the profession of obstetrics as distinct from midwifery[38] Other commentators echoed this sentiment by arguing that "as long as women untrained in the medical sciences continued to attend one half of all births, the obstetrician would never receive his due recognition."[39] The field of obstetrics was highly motivated to distinguish itself from midwifery, which was part of the domestic economy, practiced by racially, ethnically, and linguistically diverse women without a network, a professional organization, or a sense of solidarity.[40]

In 1915, presumably after practicing without regulation at least at the state level,[41] the midwives of Colorado had to take a

36. Michala Tate Whitmore, "Immediate Preservation of the Public Peace, Health and Safety": Colorado's History of Eugenic Sterilization 25 (Apr. 6, 2020) (B.A. thesis, University of Colorado Boulder) (on file with the University of Colorado Boulder Libraries).

37. *Id.* at 29.

38. Littoff *supra* note 21, at 225.

39. *Id.*

40. *See generally id.* at 225–26. Some midwives still bartered for compensation and obstetricians blamed midwives for making it hard for them to charge high fees. *Id.* at 226. However, some immigrant women who trained in the more established midwifery tradition in Europe were well paid. *Id.* at 224. Midwives were also blamed for providing care to poor women who might otherwise provide "clinical material" for medical students. *See id.*

41. Information on regulations prior to this time is currently lacking. Further, while there is general information about regulation in Spain and Mexico available, it is unclear whether or how those regulations extended to the region that is now Colorado. *See, e.g.*, Liliana López Arellano, Georgina Sánchez Ramírez & Héctor Augusto Mendoza Cárdenas, *Professional Midwives and Their Regulatory Framework in Mexico*, 12 MEX. L. REV. 2 (2019); Andrea Anguera & Angela Müller, *The Spanish Situation*, ASS'N FOR IMPROVEMENTS IN THE MATERNITY SERVS. (June 1, 2008), https://www.aims.org.uk/journal/item/the-spanish-situation.

test and apply for a license issued by the Board of Medical Examiners.[42] In a bold move by the legislature and the medical profession, instead of creating separate licensing laws—one for midwives and one for doctors—midwifery was subsumed by medicine.[43] In defining the boundaries of the medical profession, medicine became the overarching umbrella term for all kinds of healing arts, and midwifery fell under it, as it remains today.[44] The law was also careful to ensure that midwives were prohibited from using the drugs and instruments that doctors used to distinguish themselves, and that came to be equated with progress and modernization.[45]

In terms of public health and the state of science at the time, physician-assisted birth was not the superior form of maternity care.[46] Midwifery was not a subpart of the medical approach to maternity care, though that is what the legal framework implied. Further, midwifery was not regarded as the practice of medicine.[47] Yet the law incorporated midwifery as part of the practice of medicine.[48] At this moment in history

42. *See* COLO. DEP'T OF REGUL. AGENCIES OFF. OF POL'Y & RSCH., COLORADO MIDWIVES REGISTRATION PROGRAM 2 (2000). Records indicate differing years as to when midwifery began to be viewed as part of the medical community. *Id.* ("In 1917, the Colorado General Assembly created the first formal program to regulate midwives."); Tjaden, *supra* note 32, at 32 (stating that, in 1915, Colorado included midwifery "under the definition of the practice of medicine").

43. *See* Tjaden, *supra* note 32, at 32.

44. *See* COLO. REV. STAT. ANN. § 12-240-107(1) (West 2021) ("For the purpose of this article 240, 'practice of medicine' means . . . [t]he practice of midwifery . . . ."). Colorado law now includes certain exceptions that, in specific circumstances, exclude midwives and nurse midwives from the legal definition of "practice of medicine." *Id.*

45. *See* Winifred C. Connerton, *Midwifery in the Modern Era*, ENCYC. BRITANNICA https://www.britannica.com/science/midwifery/Midwifery-in-the-modern-era (last visited Apr. 16, 2022); *see also* Martelia L. Henson, Medicalized Childbirth in the United States: Origins, Outcomes, and Opposition 28 (Jan. 1, 2002) (M.A. thesis, Marshall University) (Marshall Digital Scholar).

46. Henson, *supra* note 45, at 5. "There were also a few physicians at this time coexisting with the midwives. These physicians were largely uneducated (male) health practitioners who worked without the benefit of scientific medical knowledge of the human body." *Id.*

47. *See generally* Judy Barrett Litoff, *The Midwife Throughout History*, 27 J. NURSE-MIDWIFERY 3, 9–10 (1982) (discussing the difference between moderately regulated, lay-midwives of the early twentieth century and the modern-day, medically recognized nurse-midwives).

48. *See* Samuel S. Thomas, *Early Modern Midwifery: Splitting the Profession, Connecting the History*, 43 J. SOC. HIST. 115, 127 (2009).

doctors were not the experts in childbirth, nor were they champions of women's rights and autonomy.

To be sure, gynecology and obstetrics were developed by exploiting women who were slaves, or free Black women, and using them without consent for experimentation.[49] The midwifery licensing scheme was an extension of this approach and has been a detriment to Black women, Indigenous women, and women, transgender, and gender diverse people's health in general. It was a strategic decision undertaken to advance obstetrics and not necessarily to advance women's health or families' lives. Subsuming midwifery within the practice of medicine gave obstetrics the kind of reach it wanted to attain, not just over their subspeciality of medicine, but over reproduction generally. In this way, subsuming childbirth improved medicine by enlarging its domain, but medicine did not improve childbirth.[50]

II. FUNNELING BIRTH INTO THE HOSPITAL AND CREATING A MONOPOLY OF IDEAS

At the turn of the century and into the 1920s, maternity care was a contested field where doctors were making headway into territory previously held by midwives.[51] Neither doctors nor midwives could entirely remove the pain of childbirth nor the risks of death and injury that both mothers and babies faced.[52] Although they each had their strategies, some of them

49. *See* Colleen Campbell, *Medical Violence, Obstetric Racism, and the Limits of Informed Consent for Black Women*, 26 MICH. J. RACE & L. (SPECIAL ISSUE) 57 (2021); DEIRDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, AND THE ORIGINS OF AMERICAN GYNECOLOGY 42 (2017); KHIARA BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 117–18 (1st ed. 2011); Durrenda Ojanuga, *The Medical Ethics of the 'Father of Gynaecology', Dr J Marion Sims*, 19 J. MED. ETHICS 28, 29 (1993).

50. *See* Richardson, *supra* note 2, at 2211–12 ("While a highly medicalized approach to birth is dominant in the United States, its prevalence is not explained by superior outcomes.").

51. *See* Phyllis L. Brodsky, *Where Have All the Midwives Gone?*, 17 J. PERINATAL EDUC. 48, 49 (2008) (discussing how obstetricians worked to push midwives out of the labor and delivery practice).

52. *See id.* at 48–49.

overlapping, neither had the clear upper hand.[53] Doctors used drugs to help reduce pain and forceps for manual delivery when the baby was stuck.[54] Midwives continued to trust the natural process of birth and did things to facilitate it, using gravity, manipulation, managing pain with encouragement and support, and other strategies that were often linked to cultural and religious beliefs.[55]

Before the impact of these different approaches was fully understood, and without scientific support for a new mode of childbirth, doctors undertook a concerted effort to eliminate midwifery.[56] The effort to eliminate midwifery helped create a monopoly that impacted the marketplace of ideas as well as the marketplace of goods: prices increased, quality decreased, and there were less producers.[57]

The effort to eliminate midwifery was only one of the forces contributing to this burgeoning childbirth cartel. Between the 1920s and the 1950s, multiple forces worked to exclude other actors and ideas from the childbirth "marketplace." These forces included social and political upheaval, hospitals, transportation, and the science of medicine, not to mention Jim Crow, the period of Indian "reorganization," and changing legal definitions of citizenship.[58] Each force alone warrants a deeper analysis than this Article provides. But the goal of this Article is to sketch out some of the forces that contributed to the transformation in the culture of childbirth that persists today, with particular attention given to the ways in which the law was complicit.

53. *See id.* at 50.

54. Judith Walzer Leavitt, *"Science" Enters the Birthing Room: Obstetrics in America Since the Eighteenth Century*, 70 J. AM. HIST. 281, 285–89 (1983) (discussing the history of obstetrics in America and noting how forceps and opiates were used by physicians).

55. *See id.* at 282; *see also* Susan Crowther & Jennifer Hall, *Spirituality and Spiritual Care in and Around Childbirth*, 28 WOMEN & BIRTH 173, 174 (2015) (discussing religion and midwifery).

56. Brodsky, *supra* note 51, at 49.

57. *See id.* at 50.

58. *See* IAN HANEY LÓPEZ, WHITE BY LAW: THE LEGAL CONSTRUCTION OF RACE (10th anniversary ed. 2006).

The Sheppard-Towner Act of 1921, adopted by Colorado in 1923, brought national attention and resources to maternal and infant health in the context of state-run public health initiatives.[59] Although the Act and its funding expired in 1929, its short tenure was enough to upset the status quo and make way for subsequent changes.[60] In 1935, the first year that tracked statistics for home versus hospital births, 36.9% of all births in the United States occurred in a hospital.[61] By 1940, the urban-rural balance in Colorado tipped, with 52% of the State's population living in cities and 47% living in rural areas.[62] In 1946, the Hill-Burton Act provided federal funds for hospital development and provisions for medical care of the poor.[63] The shift from home to hospital that took place in this era, and the investment in hospital infrastructure as a mainstay of communities for all kinds of health care, gave rise to the present-day terms "homebirth" and "homebirth midwife."[64] Earlier in the twentieth century, this distinction would have been meaningless because most births took place at home regardless of the care provider.[65]

59. Jess Brovsky-Eaker, *Colorado's Lukewarm Reaction to the 1921 Sheppard-Towner Act*, L. WK. COLO. (Oct. 27, 2021), https://www.lawweekcolorado.com/article/colorados-lukewarm-reaction-to-the-1921-sheppard-towner-act/.

60. *Id.*; *see also* Maureen May & Robbie Davis-Floyd, *Idealism and Pragmatism in the Creation of the Certified Midwife: The Development of Midwifery in New York and the New York Midwifery Practice Act of 1992*, *in* MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 81, 89 (Robbie Davis-Floyd & Christine Barbara Johnson eds., 2006); Neal Devitt, *The Transition from Home to Hospital Birth in the United States*, 1930–1960, 4 BIRTH & FAM. J. 47, 48 (1977) ("Several changes before 1930 influenced the attitudes of many regarding childbirth.").

61. *See* Devitt, *supra* note 60, at 58.

62. *Urban and Rural Population*, *supra* note 11.

63. Devitt, *supra* note 60, at 47; *see also* Harry Perlstadt, *The Development of the Hill-Burton Legislation: Interests, Issues and Compromises*, 6 J. HEALTH & SOC. POL'Y 77, 81 (1995). As noted by law professor Colleen Campbell, "[i]n post-slavery America, medical violence against Black women persisted well into the twentieth century, with gynecology continuing to play a key role." Campbell, *supra* note 49, at 57. Arguably, investment in hospital infrastructure supported this ongoing exploitation. *See id.*

64. *See* Devitt, *supra* note 60, at 47 ("During the period from 1930 to 1960 the proportion of births in hospitals increased from 36.9 percent [in 1935] . . . to 96 percent [in 1960] . . . .").

65. *See generally id.* (discussing the move away from home births and the subsequent rise in hospital births beginning in the 1930s).

Despite the widespread funding of hospitals, transportation to those hospitals was a challenge for many (and still is for some in the United States today, and for many people worldwide).[66] Federal investment in roadways captured the imagination of people who started thinking and planning more for transportation by car and envisioning a "rational," networked society.[67] The interstate system gained momentum with the 1938 Federal Highway Act, which imagined a world ordered by roads.[68] This development grew even during the wartime years of the 1940s and culminated with the 1956 Federal Highway Act.[69] As the United States' growing population shifted from rural to urban,[70] the development of roads coincided with the development of hospitals and contributed to the transformation in the culture of childbirth.[71] In the 1940s, only 44% of births were taking place outside of hospitals, but by 1955, the rate was 1%.[72] The fifteen years between 1940 and 1955 witnessed a huge shift in childbirth, coinciding with the massive social and cultural shifts nationwide.[73]

This transformation occurred despite the fact that the scientific basis of medicine and the profession of medicine

66. *See generally* Lee Mertz, *Origins of the Interstate*, U.S. DEP'T OF TRANSP.: FED. HIGHWAY ADMIN., http://www.fhwa.dot.gov/infrastructure/origin.htm (June 27, 2017).

67. *See generally id.*

68. *Id.* ("In this setting, the proposed interregional highway system looms as perhaps the most plausible solution to the transportation deficiencies of the modern urban area. If the cities so determine, the interregional highway system can provide an unparalleled opportunity for rebuilding along functional lines, following rational master plans.").

69. LICHTENSTEIN CONSULTING ENG'RS, GA. DEP'T OF TRANSP., HISTORIC CONTEXT OF THE INTERSTATE HIGHWAY SYSTEM IN GEORGIA 3–4 (2007).

70. *Compare* U.S. DEP'T OF COM., BUREAU OF THE CENSUS, SIXTEENTH CENSUS OF THE UNITED STATES: 1940: POPULATION 159 (1942) (noting that in 1940, the population of Colorado was 52.6% urban and 47.4% rural), *with* U.S. DEP'T OF COM., BUREAU OF THE CENSUS, THE EIGHTEENTH DECENNIAL CENSUS OF THE UNITED STATES: CENSUS OF POPULATION: 1960, at 7-19 tbl.13 (1964) (noting that in 1960, the population of Colorado was 73.7% urban and 26.3% rural).

71. Devitt, *supra* note 60, at 47.

72. MacDorman et al., *supra* note 5, at 1.

73. Devitt, *supra* note 60.

developed at different speeds.[74] For example, in 1847, scientists discovered that simple hand washing could dramatically reduce the rates of childbed fever, a disease prevalent among women who gave birth in hospitals.[75] Unfortunately, this discovery was disregarded by the medical profession for many years and was not accepted until after Louis Pasteur developed the germ theory about twenty years later.[76] Germ theory paved the way for another critical development in the science of medicine, antibiotics.[77] Antibiotics reached widespread use in the 1940s just as birth in both Colorado and the United States generally was moving out of the home and into the hospital.[78] But the forces that directed childbirth

74. Note that the development of pain reduction drugs is not included as part of the development in the science of medicine, although it is another great example of how medicine and science develop along different paths. *See* Jamie R. Abrams, *Distorted and Diminished Tort Claims for Women*, 34 CARDOZO L. REV. 1955, 1965–66 (2013). Pain during childbirth was, and remains, not well understood. *See* Nastaran Mohammad Ali Beigi, Khadijeh Broumandfar, Parvin Bahadoran, Heidar Ali Abedi, *Women's Experience of Pain During Childbirth*, 15 IRANIAN J. NURSING & MIDWIFERY RSCH. 77, 77 (2010). Despite this, and partly due to the urgings of some feminists who envisioned liberation from the pain of birth, "twilight sleep," a combination of morphine and scopolamine that reduced consciousness and increased memory loss, became a common childbirth drug. Lisa L. Chalidze, *Misinformed Consent: Non-Medical Bases for American Birth Recommendations as a Human Rights Issue*, 54 N.Y.L. SCH. L. REV. 59, 68 (2009). Twilight sleep also loosened inhibitions, which caused women to flail and scream and resulted in women being strapped to gurneys for hours, laboring alone. MARY E. RABYOR, OUR LIGHT BODY: A KUNDALINI AWAKENING TESTIMONIAL 223 n.42 (2012). *See generally* EDITH WHARTON, TWILIGHT SLEEP (1st ed. 1927) (offering a fictionized account of a woman in 1920s New York experiencing twilight sleep as a way to counteract childbirth pain).

75. *See* Imre Zoltán, *Ignaz Semmelweis*, ENCYCLOPAEDIA BRITANNICA, https://www.britannica.com/biography/Ignaz-Semmelweis (last visited Apr. 16, 2022) (explaining that Dr. Ignaz Semmelweis discovered that "students who came directly from the dissecting room to the maternity ward carried the infection from mothers who had died of [puerperal infection] to healthy mothers"); *see also Puerperal Fever*, BRITANNICA, https://www.britannica.com/science/puerperal-fever (last visited Apr. 16, 2022) (defining childbed fever as an "infection of some part of the female reproductive organs following childbirth or abortion").

76. Zoltán, *supra* note 75. Dr. Semmelweis's theory was mostly rejected by German physicists and natural scientists. *Id.*

77. *See generally* Lois N. Magner, *Biomedicine and Health: The Germ Theory of Disease*, ENCYCLOPEDIA.COM, https://www.encyclopedia.com/science/science-magazines/biomedicine-and-health-germ-theory-disease (last visited Apr. 16, 2022); Christopher Lawrence, *Biomedicine and Health: Antibiotics and Antiseptics*, ENCYCLOPEDIA.COM, https://www.encyclopedia.com/science/science-magazines/biomedicine-and-health-antibiotics-and-antiseptics (last visited Apr. 16, 2022).

78. Laura Kaplan, *Changes in Childbirth in the United States: 1750-1950*, HEKTOEN INT'L (2012), https://hekint.org/2017/01/27/changes-in-childbirth-in-the-united-states-1750-1950/.

into the hospital had begun long before these interventions made the hospital safer for birth than it had been.[79] A woman can bleed to death during childbirth regardless of whether the birth is medically supervised.[80] As many as 20% of pregnancies end in miscarriage or stillbirth that medicine did not prevent.[81] In the United States, the maternal mortality rate is rising[82] despite the fact that over 98% of births occur in hospitals.[83]

In an open marketplace of ideas, new scientific discoveries could have been evaluated along with a wide range of observations, practices, lived experiences, cultures, and belief systems to customize solutions to the individual. But, unfortunately, that is not what has happened. This period of the mid-20th century did not make scientific advances related to childbirth accessible to the masses.[84] Rather, this era narrowed the terms of decision-making to an unparalleled level of homogenization and monopolized ideas about childbirth.[85] Maternal and infant mortality rates did initially improve as medical influence increased.[86] However, this improvement cannot be attributed to obstetric management. Rather, mortality rates declined because of the antibiotic revolution, the use of blood and blood substitutes, and improved nutrition and

79. *See* Chalidze, *supra* note 74, at 67–68; Devitt, *supra* note 60.

80. *E.g.*, Jamie Morgan, *'I Thought I Was Going to Die': Ashley's Postpartum Hemorrhage Story*, UT SW. MED. CTR. (Aug. 13, 2019), https://utswmed.org/medblog/postpartum-hemorrhage-patient-story/; *see Postpartum Hemorrhage*, CHILD.'S HOSP. OF PHILA., https://www.chop.edu/conditions-diseases/postpartum-hemorrhage (last visited Apr. 16, 2022).

81. Lesley Messer, *Miscarriage and Stillbirth: Everything You Need to Know but Were Too Nervous to Ask*, GOOD MORNING AM. (Oct. 15, 2021), https://www.goodmorningamerica.com/wellness/story/miscarriage-stillbirth-nervous-65986881.

82. *See* Richardson, *supra* note 2, at 2212.

83. *See, e.g.*, BIRTH SETTINGS IN AMERICA, *supra* note 5, at 46.

84. *Id.*

85. *See, e.g.*, BIRTH SETTINGS IN AMERICA, *supra* note 5, at 18 (noting 98.4% of births occurred in hospitals).

86. *See Achievements in Public Health, 1990-1999: Healthier Mothers and Babies*, CTRS. FOR DISEASE CONTROL & PREVENTION MMWR WEEKLY (Oct. 1, 1999), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm.

antiseptic procedures.[87] These scientific advances are separate from obstetric management of birth, but they overlap in a way that supports the illusion that childbirth is not safe unless it is medically supervised.[88]

In 1941, all of these factors were at play in Colorado when Senate Bill 640 proposed a revision to the Medical Practice Act, which ended midwifery licenses with the ultimate goal of eliminating midwifery completely.[89] The law was passed with a "grandmothering" provision that allowed already-licensed midwives to practice but no new midwives to take their place.[90] This law firmly positioned medicine as the only legally recognized form of care for childbirth in Colorado.[91] Following the passage of the revised Medical Practice Act, both midwives and homebirths virtually disappeared in Colorado.[92]

Retrospective studies point out that "there is no clear-cut evidence which demonstrates that hospital managed births afforded healthy mothers with normal pregnancies a safer maternity, and there is some evidence to suggest that women who went to hospitals faced greater perils than their neighbors who chose to give birth at home."[93] I think of my grandma, who worked right next to the riveters on an assembly line during World War II, and how she was unconscious for the births of her sons in the hospital, including my dad, in 1950. She was

87. Litoff, *supra* note 21, at 229; Kaplan, *supra* note 78.

88. *See* Kaplan, *supra* note 78. Throughout the last century, it has become clearer that these scientific gains have been unevenly distributed. *See, e.g.*, NAT'L PARTNERSHIP FOR WOMEN & FAMILIES, MATERNITY CARE IN THE UNITED STATES: WE CAN—AND MUST—DO BETTER 8 (2020). Today, there are severe inequities in birth outcomes by race, as is highlighted by the increased rates of pregnancy mortality for women of color as compared to white women. *See id.* ("Racial and ethnic disparities [within the United States] are often extreme and especially impact Black and Native women and newborns."). Given this history, current outcomes are unsurprising; inequities in maternal care is part of the foundation of American medical care. *See id.* at 11–12.

89. *See generally* Tjaden, *supra* note 32, at 33 (noting how the revision of the Medical Practice Act effectively eliminated midwives, thus killing the profession).

90. *Id.*

91. *See generally id.* (acknowledging how only physicians were able to deliver babies after the revision of the Medical Practice Act).

92. *Id.*

93. Litoff, *supra* note 21, at 229.

part of a generation of women who strongly identified with modernization, progress, and the benefits of industrialization. My maternal grandmother also gave birth in the hospital during this time, though she lived a seventy-minute drive from the nearest one and stayed with a family in town at the end of her pregnancies. Both of my grandmothers were from small towns and modest means, themselves born at home. However, as their generation started giving birth en masse in the hospital, it became the norm. Medicalization was part of progress and modernization, and society was structured around this progress.[94] Still, even as the medicalization of birth was solidified by hospital infrastructure, medical training, and laws like the 1941 Colorado Medical Practice Act, a burgeoning movement for natural birth emphasized how the culture of birth remained contested.[95]

In the 1930s a British obstetrician, Grantly Dick Reed, published a book called *Childbirth Without Fear: The Principles And Practices Of Natural Childbirth* which was not published in the United States until 1944.[96] That book opened the door for Denver doctor Robert Bradley to publish his book, *Husband-Coached Childbirth*, in 1965.[97] After starting his obstetrics practice in Denver in 1952, he and his nurse, Rhondda Hartman, created the "Bradley Method" of natural birth which eventually

94. *See* Indra Lusero, *History of Midwifery Laws in Colorado*, ELEPHANT CIRCLE: THE CIRCLE BLOG (Feb. 8, 2021), https://www.elephantcircle.net/circle/2021/2/8/history-of-midwifery-laws-in-colorado; *see also Medicalization: Scientific Progress or Disease Mongering?*, NYU LANGONE HEALTH, https://med.nyu.edu/departments-institutes/population-health/divisions-sections-centers/medical-ethics/education/high-school-bioethics-project/learning-scenarios/medicalization-ethics (last visited April 8, 2022) ("Medicalization refers to the process in which conditions and behaviors are labeled and treated as medical issues. Critics have labeled this over-medicalization or disease mongering . . . . Some of this has been a product of the rapid advancement of science in the last 30 years."); *History of Hospitals*, PENN NURSING, https://www.nursing.upenn.edu/nhhc/nurses-institutions-caring/history-of-hospitals/ (last visited April 8, 2022) ("In the 1950s, 1960s, and 1970s, rising public expectations for nursing and medical attendance [resulted in] intensive care units [growing] and machines [in hospitals] bec[oming] ever more prevalent.").

95. *See supra* notes 30, 88; *infra* notes 90–93.

96. PENCE ROOKS, *supra* note 3, at 32.

97. ROBERT A. BRADLEY, HUSBAND-COACHED CHILDBIRTH at xv (Marjie Hathaway, Jay Hathaway, & James Hathaway eds., 5th ed. 2008).

became well known across the country.[98] Subsequently, Rhondda Hartman wrote *Exercises For True Natural Childbirth* and became a national figure.[99] But by the time Dr. Bradley and Rhondda Hartman promoted natural birth in Colorado, midwifery was not part of the equation due to the medical-legal infrastructure described above; medicine had a monopoly over birth.[100] In 1976, the Colorado legislature strengthened the monopoly by erasing the history of midwifery from the Medical Practice Act and deleting the section on midwifery licensure and all references to it.[101]

III. ELIMINATING FAMILIES AND THE LEGAL MEDICALIZATION OF CHILDBIRTH

Despite this history, midwifery had not disappeared in Colorado, but it was in the process of bifurcating and transforming. In 1977, Certified Nurse Midwives were formally recognized as licensed health care providers.[102] These nurse-midwives were trained in a hierarchical medical setting with doctors at the top and could only practice with physician supervision.[103] This is not the same version of midwifery that

98. *See id.* at xv, 122–23 (discussing how Rhondda Hartman was Dr. Bradley's exercise helper while also referring to her as a Canadian R.N.); *see also* Beth DeFalco, *Robert A. Bradley*, DENVER POST, Dec. 30, 1998; *We Remember—Robert A. Bradley, MD*, FRIENDS OF LA LECHE LEAGUE (Sep. 22, 2020) https://friendsoflll.org/we-remember-robert-a-bradley-md/ ("Dr. Bradley pioneered a method of drug-free natural childbirth that became known as the Bradley Method. The publication of his book, *Husband-Coached Childbirth*, in 1965, sparked nationwide interest in his efforts to bring fathers into delivery rooms.").

99. *See* BRADLEY, *supra* note 97, at 122–23 (discussing how Rhondda Hartman would go on to become a national television figure).

100. *See* Tjaden, *supra* note 32, at 30 (describing the medical control over midwives who favored natural birth in Colorado in the late 1900's).

101. *See* H.R. 1032, 50th Gen. Assemb., 2d Sess. (Colo. 1976).

102. *See* H.R. 1526, 51st Gen. Assemb., Reg. Sess. (Colo. 1977) (amending the Medical Practice Act and creating a licensing scheme for advance practice nurses trained in midwifery under the Board of Nursing).

103. *See* PENCE ROOKS, *supra* note 3, at 161–64. In 2000, the Medical Practice Act was amended to eliminate the supervision requirement for nurse-midwives. *See* COLO. REV. STAT. § 12-240-101 (2022). Text formerly codified as COLO. REV. STAT. § 12-36-106(3)(n) was deleted, which included language about the physician supervision requirement for advanced practice nurses. *Id.*

existed one hundred years before, or even forty. Nurse-midwives did not provide the non-medical care that independent midwives always had, so their existence further reinforced the formal elimination of midwifery.[104] My family was among those who sought midwifery care as an alternative to the horrible treatment they experienced in the hospital. My sister's birth in 1976 drove my parents to seek alternatives for my brother's birth in 1977. Since such an alternative did not formally exist in Colorado, they cobbled together their own plan. My younger brother was born at home in 1977 among the less than 1% of people in the United States to be born outside the domain of medicine since 1955.

By 1979, independently practicing midwives, often trained by or reclaiming practices of an older generation of midwives, began organizing through the Colorado Midwives Association (CMA).[105] In 1982, my youngest sister was born at home. At the same time, in the same county, midwife Karen Cheney, a founding member of the CMA, was charged with practicing medicine without a license for attending to families during pregnancy and birth.[106] In less than one hundred years, Colorado had gone from requiring licenses to criminally prosecuting midwives.[107] The criminal prosecution of midwives was the pinnacle of the campaign to eliminate midwifery and the ultimate manifestation of the medicalization of birth.[108]

Following Karen Cheney's prosecution in 1983, the CMA proposed the first bill to make independent midwifery

104. *See* Lucille Tower, Specializing in Normal: An Overview of Midwifery in the US (2015) (B.S. honors thesis, Portland State University) (PDXScholar) (describing the practical integration between midwives and nurse-midwifery).

105. *See* Tjaden, *supra* note 32, at 34.

106. *Id.* at 36.

107. *Id.* at 32–33, 36.

108. *See generally* Richardson, *supra* note 2, at 2222–23 (discussing contemporary prosecutions and criminalization of midwifery); Block, *supra* note 5 (noting after the criminalization of midwifery, "[d]octors swiftly transformed childbirth . . . to something [done] to [women] with medical technology.").

legal again in Colorado.[109] House Bill 1528, "Concerning Midwifery," would create an Advisory Board under the Colorado Department of Health that would regulate midwifery, define midwifery without allusion to the practice of medicine, and include a provision stating that parents have the right to decide how they give birth.[110] The House Health, Environment, Welfare, and Institutions Committee held a hearing on March 23, 1983 attended by 150 people.[111] Medical professionals including nurses, doctors, and nurse-midwives spoke in opposition to the bill, while the CMA, a homebirth father, and an OB nurse spoke in favor; everyone expressed concern about health and safety during the two hour debate.[112] A nurse-midwife proposed an amendment that would put these midwives under the control of doctors just like them. [113] This proposal was contrary to the intention of the bill: to clarify that midwifery is not medicine, and that families have a central role in birth, so the bill sponsors "killed" the bill.[114] It did not continue through the legislative process despite being voted out of committee.[115]

The CMA tried again the following year.[116] This time they did more work in preparation for running the bill including talking with the opposition about their concerns, which included the risk of "unsavory" people becoming midwives, the midwives' educational requirements, and the issue of physician supervision.[117] These concerns were taken into account in House Bill 3147, which included a requirement of "moral turpitude," the setting of educational standards, a different

109. Tjaden, *supra* note 32, at 36–37.

110. *Id.*

111. *Id.* at 37.

112. *Id.*

113. *Id.* The committee passed the bill with a 5–4 vote, but because the amendment defeated the bill's purpose, the bill was later dropped. *Id.* at 37.

114. *Id.* at 37.

115. *Id.* at 38.

116. *Id.* at 39.

117. *Id.* at 38–39.

configuration of the Advisory Board, and a role for physicians and the State Board of Health.[118] The bill reaffirmed the fact that midwifery is not the practice of medicine but attempted to address educational standards and compromise on physician supervision concerns.[119] The educational standards requirement posed a large barrier because there were no formal midwifery programs in Colorado, and very few in the country.[120] Most Colorado midwives learned by apprenticeship, a model of learning that dates back to the origins of midwifery and is also common in medical training.[121] Most midwives envisioned physician backup as an ideal but felt physician supervision was both impossible (few doctors were willing) and unnecessary.[122]

On January 16, 1984, after a seven-hour debate in the House State Affairs Committee, the bill was "indefinitely postponed," much to the shock of the representative who carried it and failed to win the support of even members of her own party on the committee.[123] The medical community lobbied heavily in opposition.[124] One member of the committee remarked that "the number of home births and lay midwives in Colorado just doesn't warrant such legislation,"[125] underscoring how effective sixty-years of effort to medicalize childbirth and eliminate midwifery had been. If you diminish something practically to extinction you can then use its smallness as evidence that it does not need to exist.

It is worth noting that it was not families or people giving birth who were lobbying against the regulation of midwifery, it

118. *See id.*

119. *Id.* at 38.

120. *See id.*

121. *See id.* at 29; *see generally* Tim Dornan, *Osler, Flexner, Apprenticeship and 'The New Medical Education'*, 98 J. ROYAL SOC'Y MED. 91 (Mar. 2015) (describing apprenticeship in modern medical education and treatment).

122. *See* Tjaden, *suupra* note 32 at 38–39.

123. *See id.* at 39.

124. *Id.*

125. *Id.* The quote came from an interview with a Republican representative who opposed the bill. *Id.*

was the medical profession.[126] Families consistently played a part in the efforts to legalize midwifery, and by extension, carve out protections for their own autonomy.[127] Following the decisive failure in 1984, a bill was drafted in 1985 proposing licensure and educational requirements under the Board of Nursing, but that bill was never run.[128] Despite the relative lack of urgency on the part of the Colorado legislature, the midwifery community was under duress, not only from the medical community who opposed them at the capitol and in the hospitals, but also from the State which continued to prosecute midwives for practicing medicine without a license.[129]

In 1990, Jean Rosburg and Barbara Parker, two midwives who were prosecuted under the Medical Practice Act, appealed their cases to the Colorado Supreme Court.[130] At trial they argued that the Medical Practice Act was unconstitutionally vague.[131] The Act says that midwifery constitutes the practice of medicine and practicing medicine without a license is prohibited.[132] The midwives argued that the Act and the medical board failed to define midwifery with sufficient specificity.[133] But the court found that the common definition of midwifery, a woman assisting another woman in childbirth, was sufficiently clear under every possible standard.[134] Although the court noted that there are exceptions to the law for those who attend childbirth in emergency situations, it did not address the potential problems with the gendered definition and seemed unconcerned about the implications of a situation where any woman assisting a woman in birth would need to be licensed to

126. *Id.* at 33, 37–38, 40.

127. *See id.* at 36 (describing the legal battle of a mother who was a founding member of a midwifery advocacy group).

128. *See id.* at 39.

129. *See id.* at 30, 36, 42.

130. People v. Rosburg, 805 P.2d 432, 434 (Colo. 1991).

131. *Id.*

132. *Id.* at 434 n.1.

133. *Id.* at 439.

134. *See id.* at 439 n.8, 440.

practice medicine.[135] This need for a distinction between midwifery and medicine is exactly what the CMA tried to address through legislation.[136] The root of this problem goes back to 1915, when the Colorado legislature subsumed midwifery into the practice of medicine despite the fact that the professions are distinct.

The court was more concerned with and perhaps distracted by the standing argument brought by the midwives and the potential implications of *Roe v. Wade*.[137] The midwives sought standing to assert the rights of pregnant women whose right to privacy was violated by the Medical Practice Act's determination of who may attend them in birth.[138] The court found that the midwives did have standing to assert the rights of pregnant women but found that the Act did not violate the privacy rights of pregnant women.[139] To arrive at that position the court spent four pages discussing the standing issue and less than a page on the substantive privacy issue.[140]

The court referred to *Roe v. Wade* to establish that "the state's interest in the life of the fetus superseded the pregnant woman's privacy right" post-viability, that childbirth happened post-viability and therefore the state's midwifery regulations could not violate the privacy rights of pregnant women.[141] The court noted that the "right of privacy has not been interpreted so broadly;" the court failed to note that the right of the State had never been interpreted so broadly either.[142] The *Rosburg*

135. *See id.* at 440.

136. *See supra* notes 103–04.

137. *See Rosburg*, 805 P.2d at 435 (discussing how the midwives who brought the case had to show "that pregnant women have a constitutional right to privacy that arguably ha[d] been abridged by the prohibition against the unlicensed practice of midwifery").

138. *Id.* at 434–35.

139. *Id.*

140. *See id.* at 435–39.

141. *Id.* at 437.

142. *Rosburg*, 805 P.2d at 437. The midwives also argued on appeal that the Medical Practice Act violated the Equal Protection Clause since it discriminates between midwives and nurse-midwives. *Id.* The court applied the rational basis test, finding no fundamental right or suspect

decision, supported by only a few sentences of analysis, went well beyond *Roe* by providing the state with virtually unbounded authority to regulate childbirth.[143] In this interpretation, the state's interest in the fetus during childbirth overrides the pregnant person and the family without bounds.[144] But, based on all that had transpired before 1992 when this case was decided, it is not surprising that the court arrived at this legal position.[145] The Colorado Supreme Court used a medical model to define and constrain childbirth and the lives of all who participate in it. This decision suggests that, because fetuses become babies who are potentially alive upon birth, every part of pregnancy that occurs once the fetus is deemed "viable" falls under the domain of the state, thus defining birth as a medical and public enterprise rather than a private one.

The court failed to account for the extensive line of cases that preceded *Roe*, which provide a more comprehensive right to privacy, reproduction, bonding, and parental decision-making.[146] But again, this follows logically in the context of the policymaking that preceded it. The court failed to consider

class, and finding that it was "beyond question that the state has a legitimate interest in protecting the health and safety of the mother and her child," after noting the educational differences between nurse-midwives and the midwives in question, noting the nurse-midwives' training was very reasonable and rational. *Id.* 437–38.

143. *See id.* at 437; Roe v. Wade, 410 U.S. 113, 116 (1973).

144. *See Rosburg*, 805 P.2d at 437. Considering the year in which the case was decided was 1992, the court's legal position is not surprising. After all, 1992 is also the year that Colorado passed the audaciously anti-gay ballot initiative which was later found unconstitutional by the U.S. Supreme Court in Romer v. Evans. 517 U.S. 620, 635 (1996).

145. *See supra* text accompanying notes 96–130.

146. *See* Meyer v. Nebraska, 262 U.S. 390, 399 (1923) (defining liberty broadly); Moore v. East Cleveland, 431 U.S. 494 (1977) (the constitution prevents East Cleveland from standardizing its children and its adults by forcing all to live in certain narrowly defined family patterns); Pierce v. Society of the Sisters, 268 U.S. 510 (1925) (stating that the constitution prevents the standardization of children and adults); Loving v. Virginia, 388 U.S. 1, 20 (1967) (recognizing the freedom to marry a person of another race); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (recognizing the right to privacy in the use of contraceptives by married people); Eisenstadt v. Baird, 405 U.S. 438, 453 (1972) (recognizing the privacy right to contraceptive use by single people); *see also* Troxel v. Granville, 530 U.S. 57, 72–73 (2000) (protecting the rights of parents to raise their children); Lawrence v. Texas, 539 U.S. 558, 599 (2003) (recognizing that even sexual deviants can decide how to conduct their private lives).

these cases because of the regime of childbirth that had been in development for three-quarters of a century as medicine and the law acted in concert to make childbirth a medical event. Instead of interpreting the privacy claim as inclusive of the rights of parents to make decisions about their families, the court interpreted the privacy claim as an uncontested medical matter.[147] The *Roe* Court relied on the scientific idea of "viability" and doctor-patient decision making to avoid the stickier 'nature of life' issues presented.[148] The Colorado Supreme Court was supported by this and a century of state regulation of midwifery.[149] This allowed the court to avoid open questions about the rights of parents to control their birthing experience, and the right of people in labor to be undisturbed by the state.

IV. LEGAL AGAIN: RISK AND REGULATION

By 1993, midwives were legal again in Colorado.[150] In the time following the Colorado Supreme Court's *Rosburg* decision, the Colorado legislature considered two bills, and the Colorado Department of Regulatory Agencies released its first report on "direct-entry midwives" in contrast with "nurse-midwives," who enter midwifery by way of nursing instead of "directly."[151] The midwives who organized for over a decade won the basic protections they sought.[152] Susan Erikson, a medical anthropologist, and Amy Colo, a Colorado midwife, explained the legalization: midwifery was "forced to appear to be something much less than it is in order to be palatable to

147. *See Rosburg*, 805 P.2d at 437–38.

148. *See* Roe v. Wade, 410 U.S. 113 (1973).

149. *See Rosburg*, 805 P.2d at 437–39.

150. *E.g.,* H.B. 1051, 59th Gen. Assemb., Reg. Sess. (Colo. 1993).

151. *See id.*; H.B. 1010, 58th Gen Assemb., 2nd Sess. (Colo. 1992); COLO. DEP'T OF REGUL. AGENCIES, SUNRISE REV. OF DIRECT ENTRY MIDWIVES (June 30, 1992) [hereinafter 1992 DORA REPORT]; Indra Lusero, *History of Midwifery Laws in Colorado*, ELEPHANT CIRCLE (Feb. 8, 2021), https://www.elephantcircle.net/circle/2021/2/8/history-of-midwifery-laws-in-colorado.

152. *See* Lusero, *supra* note 151.

the legislators."[153] This experience mirrors that of many marginalized groups, that are forced to appear to be much less than they are, and then that narrowness is given the force of law. Ultimately, the tension between what you are and how you are forced to appear takes a toll and, in this case, it impacts not only the practice of midwifery but also Colorado families.

A. *House Bill 1010*

In 1992, House Bill 1010 "Concerning the Practice of Midwifery" was introduced and given three readings in the House Judiciary Committee between January 8th and February 25th.[154] The bill initially sought to exclude the "unlicensed" practice of midwifery from the Medical Practice Act, decriminalizing what midwives had been prosecuted for in the preceding decade, while requiring midwives to register (or face criminal penalties), and disclose their professional information and affiliations to families.[155] The bill was amended extensively to "isolate and minimize the practice of midwifery while framing it within a medical-legal risk model."[156] Where the initial bill only required midwives to disclose to clients their name, address, and education, the amended bill required midwives to disclose "that the practice of midwifery is not regulated" and that registry "does not constitute licensure."[157] The amended version also increased the disciplinary powers of the Director of the Division of Regulatory Agencies where the program would be housed, and stated that the proposed law "does not constitute an endorsement of such practices," reasserting the "unlicensed" status of midwives and explicitly excluding them from the insurance provisions of Colorado

153. Susan Erikson & Amy Colo, *Risks, Costs, and Effects of Homebirth Midwifery Legislation in Colorado*, *in* MAINSTREAMING MIDWIVES: THE POLITICS OF CHANGE 289, 298 (Robbie Davis-Floyd, Christine Barber Johnson eds., 2006).

154. H.B. 1010.

155. *See id.*

156. *Id.*

157. *Id.*

law.[158] This version passed the House but was defeated in the Senate on February 26, 1992.[159]

The question of midwifery registration was then referred to the Department of Regulatory Agencies for a "Sunrise Review"[160] to evaluate the need and potential benefits of regulation and evaluate whether other more cost-effective methods could adequately protect the public.[161] The report defined midwifery, summarized contemporary perspectives on it and maternity care in general (with particular attention to rural maternity care), surveyed other states' midwifery laws, provided a short history of previous requests for regulation, analyzed the proposed regulation, and identified problems.[162] The report recommended that the state "not sanction the practice of direct entry midwifery in Colorado."[163] It found that such regulation "unfairly favors one class of providers . . . and is therefore unconstitutional."[164] The report went on to clarify that the "[c]reation of legalized lay midwifery in Colorado would require a significant change in the way [the] state views the regulation of occupations in general as well as a change in the specific philosophy of regulating health care."[165]

The report does not explain what is meant by the philosophy of regulating health care or the regulation of occupations in general, nor how it could be unconstitutional to regulate midwives.[166] But based on the foregoing description of the

158. *Id.*

159. *Id.*

160. In 1985, the "Sunrise" process was added to the Colorado Sunset Law. *See* COLO. REV. STAT. § 24-34-104.1 (2020) (originally enacted in 1985). The sunset law creates a process for the automatic review and termination of certain regulations and agencies. *See generally id.* The Sunrise component requires review of proposed regulation of occupations and professions. *Id.* This was not yet a law when the three bills concerning midwifery were introduced to the legislature in the 1980's, which is why the 1992 report is the first time the department made a report on midwifery. *See generally* 1992 DORA Report, *supra* note 151.

161. COLO. REV. STAT. § 24-34-104.1 (2020).

162. 1992 DORA Report, *supra* note 151.

163. *Id.* at i.

164. *Id*. The report did not include an analysis of this constitutional claim.

165. *Id* at 11.

166. *See id.* at i, 14.

history and some sections in the report, it becomes clear that the department was identifying the problem created when midwifery was subsumed under the practice of medicine. Within that framework, only medicalized maternity care fit within the structure and hierarchy of medical training and practice.[167] That structure is inherently at odds with the idea of midwifery as a healthcare service that is independent from the practice of medicine. Ultimately, the law does not resolve this tension; it codifies it.

B. *House Bill 1051*

In 1993, Representative Dave Owen proposed House Bill 1051, the bill that would finally legalize independent midwifery again in Colorado.[168] This bill was very similar to the 1992 amended version but with even more provisions that would isolate and minimize the practice of midwifery.[169] The bill was read and extensively amended in the House Judiciary Committee.[170] Once it passed the House, the Senate Health, Environment, Welfare and Institutions committee read the bill and made further amendments.[171] House Bill 1051 was passed on June 8, 1993, and became effective July 1st of that year.[172] Comparing the language of the final bill with the 1992 version and other legislation, it is clear that the importance of

167. The report was particularly concerned with nurse-midwifery, and this may be where the concerns of fairness and constitutionality come in, "Colorado has chosen one accepted path to the practice of midwifery. Certified nurse- midwives must acquire additional training beyond the nurse's degree and they must be then certified as a nurse- midwife. . . it should also be noted that nurse-midwives practice in Colorado under a medical model that includes physician oversight . . . ." *Id.* at 12. The report also notes "[s]hould Colorado grant direct-entry midwives the authority to practice under complete independence, it would mark a significant shift in the state's regulatory philosophy." *Id.* at 13. Nurse-midwives had only been granted licensure in 1977 and were required to have physician supervision at the time. *See* H.B. 1526, 51st Gen. Assemb., Reg. Sess. (Colo. 1977).

168. H.B. 1051, 59th Gen. Assemb., Reg. Sess. (Colo. 1993).

169. *Id.*; *see also* H.B. 1010, 58th Gen Assemb., 2nd Sess. (Colo. 1992).

170. *Amendments to House Bill 1051: Meeting Before the H. Comm. on the Judiciary*, 103rd Cong. 3–5 (Feb. 9, 1993); *see also* H.R. REP. NO. ALHB1051.004, at 1–8 (1993).

171. H.B. 1051.

172. *Id.*

professional turf and liability outweighed that of the health and welfare of pregnant people and their families.

C. *The Definition of "Midwifery"*

The definition of midwifery was one of the most interesting but subtle changes between H.B. 1010 and H.B. 1051.[173] H.B. 1010 defined midwifery as "giving the necessary supervision, care, and advice to a woman during normal pregnancy, labor and the postpartum period."[174] This is not unlike the Colorado Supreme Court's definition of midwifery in the *Rosburg* decision that overcame the vagueness challenge.[175] The problem with that definition, despite its common acceptance, is that it sweeps in an exceptionally broad range of acts and people.[176] Many of us have been midwives under this definition, myself included. The definition is tied to its traditional roots, where midwifery existed within the domestic economy and the lines between familial and maternity care roles were not so distinct. But as a legal matter, that definition presents problems: it does not fit within the framework of regulation and professionalization.[177] To accommodate this, the 1993 bill replaced the word "midwife" throughout the bill with "direct-entry midwife," so that instead of defining midwifery, the law can simply define "direct-entry midwifery" as a specific kind of job.[178]

The term "direct-entry" only makes sense in the context of medicalized birth because it refers to practicing midwifery directly instead of through a nursing program.[179] By replacing

173. H.B. 1010, 58th Gen Assemb., 2nd Sess. (Colo. 1992); H.B. 1051.

174. H.B. 1010.

175. People v. Rosburg, 805 P.2d 432, 440 (Colo. 1991).

176. *Id.* at 437.

177. H.B. 1010.

178. H.B. 1051.

179. PENCE ROOKS, *supra* note 3. There are many different terms for midwifery that attempt to distinguish the range of mode and contexts in which midwives practice. Traditional birth attendant is another term, along with "lay" midwife, there are also regionally and culturally specific terms like "granny midwife," "partera," or "dai."

midwifery in the bill with "direct-entry midwifery," it defines the profession and makes it distinct from an art or an activity that anyone could do.[180] The definition was changed in 1993 to "the advising, attending, or assisting of a woman during pregnancy, labor and natural childbirth at home, and during the postpartum period" for compensation.[181] Despite years of opposition from the medical community,[182] this bill finally carved out a niche for the independent practice of midwifery as a recognized profession.[183] This was a triumph, but a tenuous one. The bill still failed to distinguish midwifery from the practice of medicine. Instead, to gain protection from the penalties of practicing medicine without a license, midwifery fit within the regulatory scheme by becoming a "profession."[184]

D. *Further Limitations on Midwifery*

The definition of midwifery is just one way in which the law reveals this trade-off. Other requirements that place midwifery within the regulatory scheme of the medical profession include: detailed educational requirements, including training in the recognition of abnormalities and risk assessment to determine certain medical conditions that would warrant referral of a client for more medical maternity care;[185] data collection, charting, collecting specimens for screening, submitting birth certificates, and providing public health measures like prophylactic eye ointment for newborns;[186] a clear disciplinary regime including administrative, civil, and criminal penalties;[187] and participation in a professional liability insurance

180. H.B. 1051.

181. H.B. 1051. The 2001 definition no longer included "for compensation." COLO. REV. STAT. § 12-37-103(c)(3).

182. *See* Polly F. Radosh, *Midwives in the United States: Past and Present*, 5 POPULATION RSCH. & POL'Y REV. 140 (1986), http://www.jstor.org/stable/40229820.

183. H.B. 1051; *see also* COLO. REV. STAT. § 12-37-101.

184. H.B. 1051; *see also* COLO. REV. STAT. § 12-37-101.

185. COLO. REV. STAT. § 12-37-105.

186. *Id.*

187. §§ 12-37-107–08.

program.[188] Although these elements may have been required even if midwifery had developed as an independent profession outside the framework of medicine, the combination of these requirements with other limitations and proscriptions codify the conflicted relationship between midwifery and medicine into the law.

For example, while the law required that midwives carry professional liability insurance, it also excluded midwives from the professional insurance infrastructure and required them to "disclose" their outsider insurance status to consumers.[189] The bill amended the article that regulated insurance to say that "no medical malpractice insurer shall be required to provide liability coverage for unlicensed midwives who are registered and providing services . . . nor shall any medical malpractice insurer be required to include in any rate setting or classification both licensed physicians or certified nurse-midwives and unlicensed midwives."[190] The section also prohibited rate setting that would "subsidize the risks of unlicensed midwives."[191] The insurance regulation provisions reveal the deeply conflicted posture of the legislature over this issue. On one hand, midwives should be required to have liability insurance as professionals, but on the other hand, the insurance industry should not be required to provide it, and certainly should not include midwives in the same group as other health care providers.[192] In fact, the Colorado Department of Regulatory Agencies noted this in 2000, stating that, "Section 109 contains conflicting provisions that do not represent clear public policy regarding the regulation of midwifery."[193]

188. § 12-37-104.

189. H.B. 1051.

190. *Id.* at § 3 (amending COLO. REV. STAT. § 10-4-403).

191. *Id.*

192. *Id.*

193. COLO. DEP'T OF REGUL. AGENCIES OFF. OF POL'Y & RSCH., *supra* note 42, at 37. A working group was convened after the 2016 sunset of this law to examine these issues and thereafter issued a report. COLO. DEP'T OF REGUL. AGENCIES DIVISION PROS. & OCCUPATIONS, REPORT AND RECOMMENDATIONS OF THE DIRECT-ENTRY MIDWIFE RISK MANAGEMENT WORKING GROUP PURSUANT TO § 12-37-109(3)(b)(I), C.R.S. (2016) [hereinafter DORA WORKING GROUP REPORT].

The law also explicitly excluded midwives from the Health Care Availability Act, which was passed in 1988 to keep the costs of medical malpractice insurance low and maintain practices in critical areas like maternity care in rural communities.[194] An amendment to the Health Care Availability Act in H.B. 1051 made sure that the term "health care professional" excluded "a registrant conducting unlicensed midwifery."[195] This essentially meant that midwives—who make far less per birth than doctors, have a much lower annual salary, and struggle to access professional liability insurance—would be penalized.[196] Where doctors could enjoy a million-dollar cap on damages in the case of a baby born with brain damage, midwives could not.[197] The limitation on liability provided in that section "is predicated upon full licensure, discipline, and regulatory oversight and that the practice of unlicensed midwifery by registrants . . . is authorized as an alternative to such full licensure. . . and is therefore not subject to the limitations provided."[198] The law further stated that "nothing in this article shall be construed to indicate or imply that a registrant . . . is a licensed health care provider for the purposes of reimbursement by any health insurer, third party payer, or governmental health care program."[199] In short, the law ensured that midwives were excluded from the professional liability framework and that families who sought their care were excluded from health insurance reimbursement.

The "alternative to full licensure" idea is the mark of the tenuous compromise. In 2000, the Department of Regulatory

194. Dick Cooper, *Doctors Insurance Rates to Drop by 10% - Cap on Malpractice Awards Aids Reduction*, DENVER POST (Aug. 5, 1989).

195. H.B. 1051, 59th Gen. Assemb., Reg. Sess. (Colo. 1993).

196. *See* U.N. POPULATION FUND, INT'L CONFEDERATION OF MIDWIVES & WORLD HEALTH ORG., THE STATE OF THE WORLD'S MIDWIFERY 54–55 (2021), https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302_0.pdf;
Indra Lusero, *Making the Midwife Impossible: How the Structure of Maternity Care Harms the Practice of Home Birth Midwifery*, 35 WOMEN'S RTS. L. REP. 406, 428 (2014).

197. *See* Cooper, *supra* note 194.

198. COLO. REV. STAT. § 12-37-109(1)(b) (repealed 2011).

199. *Id.*

Agencies recommended the change from a "registry" to a "licensure" program because "[a] true registration program requires no education or experience standards" and that:

> [i]t makes economic sense to allow direct entry midwife attended home birth as an option for consumers who are eligible for Medicaid and other third party insurance . . . . The state expends large amounts of resources on low income births and low birth weight infants. It would seem to be in the best interest of the state to utilize a safe, effective, low cost alternative to physician attended births in low risk pregnancies rather than legislating against such a practice.200

This conflicted logic remains in the law today[201] and demonstrates how the law embodies the conflict between medicine and midwifery, despite the health and welfare of pregnant people and families. While this provision does not make a practical difference, as a family would be unlikely to recover a large amount of damages from an uninsured midwife, the symbolic significance of its inclusion in the law was clear: midwifery presented a "risk" that the state was unwilling to bear.[202]

This lack of respect for midwifery is evident in other areas of the law as well. For example, the law asserts that midwives will be liable for their own negligence but that "no licensed physician, nurse, prehospital emergency medical personnel, or health care institution" would be liable for midwives.[203] This section also refers to a well-established part of medical malpractice law that makes doctors vicariously liable to all practitioners under their supervision, which is the model that independent midwifery challenges. This section was written

200. COLO. DEP'T OF REGUL. AGENCIES OFF. OF POL'Y & RSCH., *supra* note 42, at 27, 38.

201. *See, e.g.*, COLO. REV. STAT. § 12-225-112 (2022).

202. This issue continues. *See, e.g.*, DORA WORKING GROUP REPORT, *supra* note 193, at 1.

203. § 12-25-112(1).

to clarify that consultation with, and education of, midwives does not create a supervisory relationship, which makes it possible for midwives and doctors to cultivate collaborative relationships.[204] These provisions are not unreasonable; midwives should certainly be liable for their own negligence. But the fact that such standard rules of law are stated and restated here reveal more than just the technical requirements of law-making. There are no comparable provisions in the laws regulating acupuncturists, massage therapists, chiropractors, podiatrists, dentists, doctors, or physical therapists.[205]

The law regulating advance practice nurses states that "[n]othing . . . shall be construed to confer liability on an employer for the acts of an advanced practice nurse that are outside the scope of employment."[206] The language in the direct-entry midwifery law goes well beyond this and has a punitive, moralizing tone as if midwives and their clients do not deserve the protection of the law because what they are doing (physiologic birth at home) is so unconscionable.[207] To restate an important point, this fear is not based on any evidence that birth is riskier at home than at a hospital, or that it is safer with doctors than with midwives.[208] This is a fear about the professional boundaries of medicine couched in arguments about "health and safety."[209]

204. *Id.*

205. *See generally* Health-Care Professions and Occupations, COLO. REV. STAT. § 12-200-101–310-109 (2022).

206. § 12-225-113(4).

207. *Compare* § 12-225-112(1) (declining to extend any liability to a midwife's employer), *with* § 12-225-113(4) (extending liability to a nurses' employer).

208. NAT'L ACADS. OF SCIS. ENG'G MED., *supra* note 3, at 207; Elizabeth Nethery, Laura Schummers, Audrey Levine, Aaron B. Caughey, Vivienne Souter & Wendy Gordon, *Birth Outcomes for Planned Home and Licensed Freestanding Birth Center Births in Washington State*, 138 OBSTETRICS & GYNECOLOGY 693, 696 (2021); Judy Koutsky, *Should You Choose an OB-GYN or a Midwife?*, PARENTS, https://www.parents.com/pregnancy/my-body/pregnancy-health/doctor-right-how-to-choose-an-ob-gyn-or-midwife (July 8, 2021).

209. *See* Koutsky, *supra* note 208.

E. *Informed Consent Requirements*

Informed consent requirements further express the law's disapproval of midwives and their clients. Informed consent requirements obligate midwives to inform their clients of their educational background, training, contact information, liability insurance, emergency plan, and the complaint filing process.[210] Further, midwives must inform their clients about the alternatives to direct-entry midwifery, the risks of birth with attention to home versus hospital, and the lack of vicarious liability for doctors.[211] Not only do they have to get consent for each item with the client's initials, one by one, but they must also read the information aloud to their clients.[212] While there is nothing inherently wrong with informed consent requirements, the requirements imposed on midwives are far more extensive than those imposed on other professions.[213] In fact, the Medical Practice Act is entirely silent about informed consent. [214]

Although there are informed consent requirements for other "alternative health care"[215] providers, they are not quite so extensive, and certainly not so paternalistic. The informed consent provision for acupuncturists, for example, requires disclosure of educational background, training, contact information, and how to file a complaint.[216] It also requires a statement indicating that the client is entitled to information about the therapy and a second opinion, that the client may stop therapy at any time, and that sexual relationships

210. §§ 12-225-105(1), 106(5)(a)(III).

211. § 12-225-106(5)(a)(III).

212. § 12-225-106(5)(b).

213. *Compare* §§ 12-225-105(1), 106(5)(a)(III) *with* § 12-240.

214. § 12-240.

215. Alternative health care, sometimes referred to as complementary or integrative health care, is a term used to describe approaches to health care-related services that are not as mainstream or conventional in Western culture (e.g. acupuncture, chiropractic manipulation, naturopathy, yoga, aromatherapy, massage therapy). *See What Are Alternative Healthcare Services? How Do I Know if They Are Covered?*, NH HEALTHCOST (Apr. 16, 2018), https://nhhealthcost.nh.gov/guide/question/what-are-alternative-healthcare-services-how-do-i-know-if-they-are-covered.

216. § 12-200-105(1).

with the acupuncturist are not appropriate.[217] These are not unreasonable requirements, though they do go beyond the informed consent requirements written into the law regulating doctors,[218] and they suggest an uneasiness with the profession and practice of acupuncture.[219] But even that does not go as far as the midwifery laws that required enumeration of risks and reference to vicarious liability, as well as line item initialing and oral reading.[220]

This not only implies that midwives and their clients cannot make good decisions, but also creates only one path for good decision-making: a risk-based, medical, legal, liability-oriented path.[221] This risk model is built into the law through these liability components and the informed consent facade, but mainly in its prohibition against midwives attending to any woman with "increased risk of medical or obstetric or neonatal complications."[222] This hearkens back to the 1915 law which subsumed midwifery under the practice of medicine even though midwifery was the safer and more established form of maternity care.[223] Despite the law's implication, informed consent is particularly important to midwives, whose core competencies include these guiding principles, as recognized by the Department of Regulatory Agencies:

217. § 12-200-105(1)(c).

218. *See* § 12-240 (failing to mention informed consent requirements).

219. *Id.*

220. §§ 12-225-106(5)(b).

221. § 12-225-112(1).

222. § 12-225-106(1)–(4). Limiting their scope of practice to "low-risk" and "normal" birth is one of the fundamental ways that direct entry midwives have come back from the brink of extinction and achieved legalization all over the country. It has become the standard, accepted framework. And though it suggests a kind of collaboration between midwives and doctors that does not fully exist yet, few people question this framework today. But there remains a wide range of issues the medical community defines as high risk that midwives do not. And so, this problem, that midwifery is beholden to medicine, remains. Examples of places where there is disagreement: vaginal birth after cesarean, breech birth, multiples, and "post-dates" (the amount of time past the due date that a person and her baby can safely go before going into labor).

223. § 12-240-107.

> Midwives work in partnership with [people] and their chosen support community throughout the caregiving relationship.
>
> Midwives respect and support the dignity, rights and the ability of the [people] they serve.
>
> Midwives are committed to addressing inequities in health care status and outcomes.
>
> Midwives work as autonomous practitioners, and they collaborate with other health care and social service providers where appropriate.
>
> Midwives work to optimize the well-being of the mother-baby unit as the foundation of caregiving.
>
> Midwives recognize the empowerment inherent in the childbearing experience and strive to support women to make informed decisions and take responsibility for their own well being. . . .[224]

The reality is that there is more than one way to make decisions about pregnancy and birth and none of them are guaranteed.[225] Colorado legislators, uncomfortable with this, use midwifery law to strike a compromise: tacit acceptance that there might be other ways to make good decisions, as long as they are framed within the medical-legal risk model.[226] It is a fraught compromise that constrains the decision-making of not only midwives but also the families they serve. But it is a compromise that ushered midwifery back into legal recognition.

224. MIDWIVES ALL. OF N. AM., THE MIDWIVES ALLIANCE CORE COMPETENCIES 1–2 (2014), https://mana.org/pdfs/MANACoreCompetenciesFINAL.pdf.

225. Another core competency for midwives is to "integrate clinical or hands-on evaluation, theoretical knowledge, intuitive assessment, spiritual awareness and informed consent and refusal as essential components of effective decision making." *Id.*

226. *See* People v. Rosburg, 805 P.2d 432, 437 (Colo. 1991); *see also Lusero*, *supra* note 151.

F. *1992 Sunrise Report*

The 1992 Sunrise Report was an anomaly in that it advised against the "sanction" of midwifery.[227] Subsequent DORA reports readily accepted the practice of midwifery and made recommendations for improvement to the law.[228] The 1995 Sunset Report, made after only two years of regulation, is a dramatic contrast to the 1992 report.[229] In it, DORA acts like regulating midwives is commonplace, treats the practice as a profession, and makes a lot of recommendations to that end.[230]

Many of those recommendations were subsequently included in the law, such as grounds for discipline, governmental immunity, confidentiality of records, procedures for registration denial, waiting period for reinstatement, subpoena powers, the role of administrative law judges, and modifications to training and education.[231] Other recommendations did not survive the extensive readings and amendments in the House and Senate that preceded passage of Senate Bill 49 in 1996.[232] These recommendations included creating a registry of apprentice midwives, allowing other licensed care providers to be simultaneously registered as midwives, and expanding the scope of practice to permit use of four emergency and prophylactic drugs.[233]

The law was again up for review in 2001, after eight years of regulation in this modern configuration.[234] In its 2000 report, DORA noted that not only did six years' worth of data suggest home-birth midwives had better outcomes than births in

227. *See* 1992 DORA REPORT, *supra* note 151, at 13.

228. *See* COLO. DEP'T. OF REGUL. AGENCIES OFF. OF POL'Y & RSCH., COLORADO REGISTRATION OF DIRECT-ENTRY MIDWIVES: 1995 SUNSET REVIEW 1 (1995) [hereinafter 1995 DORA REPORT].

229. *See id.* at 1, 8.

230. *See id.* at 4–5, 18.

231. *See id.* at 26–34, 39–40.

232. S.B. 96-049, 60th Gen. Assemb., Reg. Sess. (Colo. 1996).

233. *Id.* Part of this recommendation passed: licensed acupuncturists could be licensed and registered as midwives.

234. *See* Erikson & Colo, *supra* note 153, at 228, 301; S.B. 01-118, 65th Gen. Assemb., Reg. Sess. (Colo. 2001).

Colorado hospitals, but that "consumers do not file the majority of complaints received by the program."[235] In fact, "[m]ost complaints are filed by hospital administrators or medical professionals," and many of which are found to be compliant with the act.[236] Regulation provided a measure of protection but also provided a new avenue by which medicine could strive to maintain its monopoly on birth.

Despite the fact that DORA made extensive recommendations for improvement to the law in 2001, the Colorado Midwives Association did not recommend any changes, presumably hoping instead to take a break from legislative battles and get a ten-year sunset;[237] which they did. Senate Bill 118 only encompassed the changes to educational requirements in 2001 which, after several readings and amendments passed (despite continued opposition from the medical community), increased educational requirements for midwives but did not expand or clarify their scope of practice.[238] Unfortunately, the DORA report's most extensive recommendations went unconsidered and most of the conflict written into the law carried into the twenty-first century.[239] After a ten-year sunset, the law was again up for review in 2011.[240]

V. DEFINING TWENTY-FIRST CENTURY MIDWIFERY IN COLORADO: A PATH FORWARD

I experienced the Colorado midwifery law firsthand in 2003 after the birth of my youngest child, at home, with the assistance of a direct-entry midwife. I was intrigued by the

235. COLO. DEP'T OF REGUL. AGENCIES OFF. OF POL'Y & RSCH., COLORADO MIDWIVES REGISTRATION PROGRAM: 2000 SUNRISE REVIEW (2000), at 17–23 [hereinafter 2000 DORA REPORT].

236. *Id.*

237. *See* Erikson & Colo, *supra* note 153, at 302.

238. *See* S.B. 01-118; *see also* Erikson & Colo, *supra* note 153, at 302.

239. *See* S.B. 01-118; 2000 DORA REPORT, *supra* note 235, at 25–40.

240. *See* S.B. 11-088, 68th Gen. Assemb., 1st Reg. Sess. (Colo. 2011); *see also* H.B. 1172, 72d Gen Assemb., 1st Reg. Sess. (Colo. 2019) (providing that all regulatory departments must analyze and evaluate the rules, regulations, and function of divisions every ten years).

profession and why the law worked as it did, especially because I noticed contradictions and restrictions that were illogical. For example, in 2003, if someone's perineum tore during birth with a direct-entry midwife, the midwife could not provide sutures, but instead had to transfer care to a physician.[241] Because I experienced this, I felt frustrated and curious about this limitation in the law, especially because midwives are trained to provide sutures for mild tears like mine.[242] I personally experienced how the legal framework of birth constrained decision-making in accordance with medicine and not necessarily in alignment with what people want or need.

Midwives have to choose between following the letter of the law and practicing what they and the parents believe is best for all concerned. The ideological spaces and birth arts that homebirth midwives preserve are significant, yet legalization has forced many midwives to abandon some midwifery arts practices, or at the very least strategically remove certain aspects from public view.[243]

My experience with these contradictions as a parent, and experiences I had as a doula supporting people in labor, inspired me to understand what role the law plays in childbirth. In fact, it inspired me to go to law school.

One experience that was particularly disturbing took place when a midwife called me, having heard I was in law school to learn about these things. She was a registered direct-entry midwife under the care of another registered direct-entry midwife when she went to the hospital late in her pregnancy because they could no longer find fetal heart tones. Her baby was stillborn. Subsequently, a complaint was filed by the hospital *against her as a midwife*, even though she was the client in that case. While grieving her stillbirth, she received a notice

241. *See* Erikson & Colo, *supra* note 153, at 301.

242. *See Making Suturing Better as a Midwife*, MIDWIFE DIARIES, https://midwifediaries.com/blog/making-suturing-better-midwife (last visited Apr. 16, 2022).

243. Erikson & Colo, *supra* note 153, at 305.

from the state of a complaint against her as a direct-entry midwife lodged by one of her own hospital care providers.

I have been involved with legislative efforts to improve the legal architecture of birth since then, starting in 2010 when I was part of an effort to prohibit shackling of incarcerated people during pregnancy and birth.[244] In 2011, I worked on the sunset for the direct-entry midwifery law and succeeded in addressing several things,[245] including the places in the law that were explicitly hostile to midwives.[246] Three paragraphs were removed: the legislative declaration that did not endorse midwifery, the exclusion of midwives from the liability cap on damages, and the exclusion of midwives from reimbursement by health insurers.[247]

The law was also updated in the sunset processes of 2016 and 2021, but one of the issues that remains to this day, with clear echoes of this history, is the designation of these providers as "licensed."[248] Midwives were licensed between 1900 and 1940, but thereafter licensure was explicitly eliminated.[249] Legislators sought licensure for midwives in the 1980s, but were ultimately unsuccessful.[250] The compromise of the 1990s included provisions along these lines: "unlicensed midwifery by registrants . . . is authorized as an alternative to such full licensure."[251] Despite the fact that the regulating agency itself acknowledged that "[t]he Colorado direct-entry midwife

244. *See* S.B. 10-193, 67th Gen. Assemb., 2d Reg. Sess. (Colo. 2010).

245. *See* Melanie Asmar, *Indra Lusero's Pitch to Help Colorado Midwives Is Catching Heat in the Legislature*, WESTWORLD (Jan. 27, 2011, 4:00 AM), https://www.westword.com/news/indra-luseros-pitch-to-help-colorado-midwives-is-catching-heat-in-the-legislature-5111481; S.B. 11-088, 68th Gen. Assemb., 1st Reg. Sess. (Colo. 2011). The prohibition on being simultaneously licensed as a nurse and registered as a direct entry midwife has been eliminated, the definition of "natural childbirth" was changed, additional disclosure/informed consent requirements were added, midwives could now obtain and administer Vitamin K, Rhogam, antihemorrhagic drugs, eye prophylaxis, and intravenous fluids. *See id.*

246. *See* S.B. 11-088.

247. *See id.*

248. *See* H.B. 16-1360, 70th Gen. Assemb., 2d Reg. Sess. (Colo. 2016).

249. *See* Tjaden, *supra* note 32, at 32–33.

250. *See id.*, at 33; Lusero, *supra* note 151.

251. COLO. REV. STAT. § 12-225-112 (1993).

registration program is in fact a licensing program,"[252] and the fact that the law was changed in 2011 to remove reference to "unlicensed registrants," [253] not to mention that most states now license these providers[254] and their licensure is widely regarded as important,[255] this remains one of the most contentious issues.[256] This should be no surprise.

The consequence of this history in Colorado, and in the various ways it has played out across the country, includes the fact that we spend more than any other developed nation on maternal health, but have worse outcomes—including rising maternal mortality rates and inequities in outcomes based on race.[257] In addition, discrimination, mistreatment, and harm regularly occur during the perinatal period contributing to poor birth and health outcomes for both parent and child.[258] In 2019, one in six people surveyed reported experiencing one or more types of mistreatment during perinatal care, with the rate being

252. 2000 DORA REPORT, *supra* note 235, at 27.

253. *See* S.B. 11-088, 68th Gen. Assemb., 1st Reg. Sess. (Colo. 2011).

254. *See Pushstates in Action*, THE BIG PUSH FOR MIDWIVES CAMPAIGN, https://www.pushformidwives.org/pushstates_in_action (last visited Apr. 21, 2022).

255. BIRTH SETTINGS IN AMERICA, *supra* note 5; *see also* Saraswathi Vedam, Kathrin Still, Marian MacDorman, Eugene Declrecq, 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 8.

256. This was directly addressed during the 2021 Sunset Review, but stakeholders could not agree on a path forward at that time. *See* ELEPHANT CIRCLE, COLORADO'S DIRECT-ENTRY MIDWIFERY LAW AND PROGRAM (Mar. 2020), https://static1.squarespace.com/static/57126eff60b5e92c3a226a53/t/602426e600f9fc1cffcf740e/1612982021935/Full+Report+to+DORA+for+Sunset+2021.pdf (citing SAKALA & CORRY, *supra* note 5).

257. NAT'L P'SHIP FOR WOMEN & FAMS., MATERNITY CARE IN THE UNITED STATES: WE CAN — AND MUST — DO BETTER 7 (Feb. 2020), https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf; *see also* Munira Z. Gunja, Roosa Tikkanen, Shanoor Seerval & Sara R. Collins, *What Is the Status of Women's Health and Health Care in the U.S. Compared to Ten Other Countries?*, COMMONWEALTH FUND (Dec. 19, 2018), https://www.commonwealthfund.org/sites/default/files/2018-12/Gunja_status_womens_health_sb.pdf.

258. *See* Katie Hamm, Cristina Novoa, Shilpa Phadke & Jamila Taylor, *Eliminating Racial Disparities in Maternal and Infant Mortality*, CTR. FOR AM. PROGRESS (May 2, 2019), https://www.americanprogress.org/issues/women/reports/2019/05/02/469186/eliminating-racial-disparities-maternal-infant-mortality/.

higher in hospitals and for people of color.[259] Further, despite the fact that midwives are the providers shown to provide optimal care, they attend less than 20% of births in Colorado.[260]

In 2021, Colorado became the first state to pass comprehensive legislation to address inequities in birth outcomes through a package of "Birth Equity Bills," which some referred to as the Colorado Momnibus,[261] in reference to comprehensive federal legislation known as the Momnibus Act, which was also introduced in 2021 and similarly targets birthing inequities.[262] The Colorado legislation consisted of three bills, including the direct-entry midwifery sunset, Senate Bill 2021-101, along with Senate Bill 2021-193 and Senate Bill 2021-194.[263] Advocates included Senate Bill 101 in the package because they understood that our failing maternal health outcomes today are directly linked to the turbulent legal history of midwifery, and that improvements cannot be achieved without rectifying this history.[264] But the Colorado Birth Equity Bills went beyond the direct-entry midwifery law to address the

259. Saraswathi Vedam, Kathrin Still, Tanya Khemet Taiwo, Nicholas Rubashkin, Melissa Cheyney, Nan Strauss, Monica McLemore, Micaela Cadena, Elizabeth Nethery, Eleanor Rushton, Laura Schummers & Eugene Declerqc, *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, 16 REPROD. HEALTH 77, 83–84 (2019).

260. BIRTHPLACE LAB, MIDWIFERY INTEGRATION STATE SCORING (MISS) SYSTEM REPORT CARD: COLORADO 1 (2018), https://www.birthplacelab.org/wp-content/uploads/2018/02/Colorado.pdf; *see also* U.N. POPULATION FUND, THE STATE OF THE WORLD'S MIDWIFERY 7–12 (2021), https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302.pdf ("Midwives provide many essential clinical SRMNAH interventions and can play a broader role in activities such as advancing primary health care and UHC, responding to violence against women, and addressing sexual and reproductive rights.").

261. Alexa Richardson, *Colorado Passes Landmark Birth Equity Bill Package*, HARV. L.: BILL OF HEALTH (June 22, 2021), https://blog.petrieflom.law.harvard.edu/2021/06/22/colorado-passes-landmark-birth-equity-bill-package/.

262. Black Maternal Health Momnibus Act, H.R. Res. 959, 117th Cong. (2021).

263. Richardson, *supra* note 261; Sunset Direct-Entry Midwives, S.B. 21-101, 73rd Gen. Assemb., 2nd Reg. Sess. (Colo. 2021).

264. *See* Kayla Frawley, *Op-Ed: Colorado Birth Equity Bills Could Bring Better Maternity Care*, WESTWORD (April 18, 2021, 7:37 A.M.), https://www.westword.com/news/colorado-birth-equity-bill-maternity-care-op-ed-11946967#.

policy architecture for birth in multiple ways clearly implicated by this history.[265]

Senate Bill 193, "Protection of Pregnant People in Perinatal Period," established several provisions focusing on the human rights of pregnant people.[266] First, insurers offering malpractice insurance must provide information about their labor and delivery policies to the Colorado Department of Public Health and Environment (CDPHE) upon request (this is due to reports from providers that malpractice liability policies restrict their ability to practice).[267] Second, pregnant people are now treated the same as all other medical decision makers in the advance directives law.[268] The Colorado Civil Rights Division will receive reports when maternity care fails to be culturally congruent, maintain dignity, privacy, or confidentiality, ensure freedom from harm and mistreatment, or provide informed choices or continuous support.[269] All facilities where people give birth must demonstrate to the CDPHE that policies allow every birthing person to have a support person (companion or doula) with them in addition to a partner or spouse, prioritize newborns' bonding with their families, do not exclude from care or interrupt anyone experiencing physiologic birth without informed consent from the birthing person, have a process for receiving patient information from any provider regulated by Title 12 (this includes midwives), and create a plan for receiving and transferring patients across levels of care.[270]

Facilities that incarcerate people (such as jails, correctional facilities, private contract prisons, or Department of Human Services facilities) must meet minimum standards for the care of pregnant people.[271] These standards include reporting on exceptional use of restraints, reporting the place and numbers

265. *See id.*; Richardson, *supra* note 261.

266. S.B. 21-193, 73rd Gen. Assemb., 2d Reg. Sess. (Colo. 2021).

267. *Id.* at § 1; COLO. REV. STAT. § 10-4-106.5.

268. S.B. 21-193, at § 2; COLO. REV. STAT. § 15-18-105.

269. S.B. 21-193, at § 7; COLO. REV. STAT. § 23-43-305.

270. S.B. 21-193, at § 8; COLO. REV. STAT. § 23-3-126.

271. COLO. REV. STAT. § 17-1-113.7(2)(b); COLO. REV. STAT. § 17-1-114.5.

of births, training staff on safe and respectful treatment, providing perinatal care services, providing nutrition, safety measures, menstrual products, breast pumps, education on pregnancy and birth, counseling for particularly vulnerable populations, having policies that are trauma-informed, prioritizing newborn bonding, and supporting physiologic birth and informed consent.[272]

Notably, facing opposition from COPIC—a major medical professional liability insurance provider—the provision to extend the statute of limitations for informed consent violations was removed from the bill.[273] In addition, facing fear of malpractice insurance industry reprisal, the provision to require policies to cover vaginal births after cesarean (VBAC) was changed to require disclosure of policies to CDPHE as part of CDPHE's expanded data collection regarding perinatal care.[274]

Senate Bill 194, "Maternal Health Providers," focuses on payment, data, and aligning systems.[275] Public and private health insurance plans must reimburse providers in a manner that promotes high-quality, cost-effective, and evidence-based care, promotes high-value evidence-based payment models, and prevents risk in subsequent pregnancies.[276] Providers who regularly provide care during labor and birth must facilitate patient transfers across levels of care and in coordination with other providers to ensure patients do not lose access to care.[277]

272. *See* S.B. 21-193; U.S. DEP'T OF JUST., PARENTING PROGRAM STANDARDS 2–4 (Jan. 20, 1995), https://www.bop.gov/policy/progstat/5355_003.pdf; *see generally State Standards for Pregnancy-Related Health Care and Abortion for Women in Prison*, ACLU, https://www.aclu.org/state-standards-pregnancy-related-health-care-and-abortion-women-prison-0 (last visited May 7, 2022).

273. *See* S.B. 21-193.

274. S.B. 21-194, 73rd Gen. Assemb., 2d Reg. Sess. (Colo. 2021).

275. S.B. 21-194; COLO. REV. STAT. § 10-16-014(3)(d).

276. *Id.* § 12-30-118.

277. *Id.* § 25-2-112(7)(a)–(b).

The birth certificate worksheet will collect information on the intended place of birth.[278]

CDPHE and the Maternal Mortality Review Committee have expanded data collection and reporting duties to include input and feedback from people who are directly impacted, with a focus on racial and ethnic minority groups and non-profits and community-based groups.[279] Further, the CDPHE and Maternal Mortality Review Committee have made recommendations to improve collection and public reporting of data related to perinatal health—with a focus on data from storytelling, race/ethnicity/disability data, an uptake of trainings on bias/discrimination, and data on incidents of mistreatment.[280] These recommendations include studying the use of research evidence in Colorado policies related to the perinatal period and extending Medicaid coverage postpartum so that people who are qualified during pregnancy will maintain coverage for twelve months after birth.[281]

CONCLUSION

The policy work needed to carve a path for perinatal care that prioritizes the health and wellbeing of pregnant people and their families is by no means complete. The legal history of midwifery in Colorado illustrates how the medicalization of childbirth occurred, the consequences of it, and some of the core legal principles needed to counteract it: independent midwifery and the authority of pregnant people to make decisions about their care. Colorado's 2021 Birth Equity Bills, and the federal Momnibus Act are examples of how far-reaching policy change needs to dismantle the legal architecture of birth that was originally built to advance the interests of professional white men over the interests of everyone else. The racism embedded

278. *Id.* § 25-52-104(5)(a)–(c); LEGIS. COUNCIL STAFF, FINAL FISCAL NOTE, S.B. 194, at 2 (Colo. 2021).

279. S.B. 21-194, 73rd Gen. Assemb., 1st Reg. Sess. § 6; § 25-52-104(5)(d).

280. *Id.*

281. §§ 25-52-104 (4)–(7).

within the status quo must be eliminated at the structural level to bring about a perinatal care system that truly works for the health and wellbeing of all birthing people. This cannot be achieved through implicit-bias trainings or reducing interpersonal discrimination. Infrastructure geared toward honoring birth as a physiologic process without guaranteed outcomes that no profession has dominion over is necessary.