EFiled: Dec 19 2014 10:42AM EST
Filing ID 56498232
Case Number 593,2014

IN THE SUPREME COURT OF THE STATE OF DELAWARE

KAREN S. WEBSTER Petitioner Below, Appellant, v. DELAWARE BOARD OF MEDICAL LICENSURE AND DISCIPLINE, Defendants Below, Appellee.	)	C.A. No. 593, 2014 Court Below: The Superior Court of the State of Delaware, C.A. No.: N13A-05-011 FSS

BRIEF OF AMICUS CURIAE, IMPROVING BIRTH ET AL. IN SUPPORT OF APPELLANT KAREN WEBSTER, URGING THE COURT TO REVERSE THE DECISION BELOW

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STATEMENT OF INTEREST

The fourteen amicus curiae are organizations that address childbirth and midwifery in the United States with particular attention to the ability of families to access a range of maternity care options, and the ability of midwives like the Appellant to access education, credentialing, and professional representation. The amici are interested in this case because of how it impacts their members and the midwives they educate, credential and support, because of how it impacts families in Delaware whose access to midwives like the Appellant are limited, and because they recognize the essential role of midwives in the health care system and seek to ensure widespread access and equitable systems. Together these amici offer the Court a substantive understanding of the questions it faces in deciding Ms. Webster's appeal, and will help the court put this decision in context with regard to how it may impact the profession, the health care system, and Delaware families.

ARGUMENT

The amici submit this brief based on our belief that all families should have access to the option of midwifery care during pregnancy and birth, that midwifery care is an essential part of all health care systems, and that as a result, this court should find in favor of the appellant, Karen Webster, a Certified Professional Midwife.

I. Midwifery is Not the Practice of Medicine.

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

A. Midwifery and Medicine Are Two Distinct Models of Care.

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

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

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

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

More recently, researchers with the Cochrane Collaboration identified and compared what they called the "midwife-led model of care" with other models of care, including obstetrician-provided care, family doctor-provided care, and shared models of care. *See* Marie Hatem, *Midwife-led versus other models of care for*

childbearing women, The Cochrane Collaboration (2009), http://apps.who.int/rhl/reviews/CD004667.pdf. The authors distinguished the midwife-led model and described it as follows:

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

In modern maternity care systems around the world, midwives as distinct from physicians, are the primary caregivers for normal, healthy women at all stages of their reproductive lives, including pregnancy and childbirth. *Id.* at 2. The American childbirth setting, however, has inserted a *primary* caregiver whose specialty is surgery and pathology (obstetrician), where someone whose specialty is normal childbirth (midwife) should be; although their fields overlap, they're clearly distinct. Physicians might, in fact, benefit from studying midwifery, as is the case in the Netherlands, where physicians who wish to provide care for normal births are required to study midwifery formally for one year. Ted (G. J.) Kloosterman, *Why Midwifery?*, The Practising Midwife, Spring 1985, at 10.

B. Legal Precedent Establishes Midwifery as a Distinct Profession.

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

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

In states that have not explicitly addressed midwifery by statute or regulation (*un*like Delaware), midwives charged with practicing medicine without a license look to the facts of the case and the language of the state's medical practice act. In the majority of such cases, the courts have found that midwifery is *not* the practice of medicine. *See, e.g., Albini v. Conn. Med. Examining Bd.*, 72 A.3d 1208 (Conn. App. Ct. 2013); *Banti v. State*, 289 S.W.2d 244 (Tex. Cr. App. 1956); *Carr v. Dep't of Health*, District of Columbia Office of Administrative Hearings, C.A. No. 2011-DOH-00002 (May 22, 2013); *Peckman v. Thompson*, 745 F. Supp. 1388 (C.D. Ill. 1990); *State Bd. of Nursing v. Ruebke*, 913 P.2d 142 (Kan. 1996); *State v. Mountjoy*, 891 P.2d 376 (Kan. 1995).

In cases where courts *have* held midwifery to fall within the definition of medicine, the medical practice act in question included treatment of a "condition" or otherwise explicitly included pregnancy and birth. *See, e.g., Bowland v. Mun. Ct. for Santa Cruz*, 134 Cal. Rptr. 630 (Cal. Sup. Ct. 1976); *Smith v. State*, 459 N.E.2d 401 (Ind. App. 1984); *State ex rel. Mo. State Bd. of Registration for the Healing Arts v. Southworth*, 704 S.W.2d 219 (Mo. 1986). However, in none of these cases did the state also recognize non-nurse midwifery by statute.

Even when separate professions are identified and permitted, scopes of practice overlap. Consider, for example, the overlapping practice areas of psychiatrists and social workers (mental health), ophthalmologists and optometrists

(eye care), and physiatrists and physical therapists (physical rehabilitation). The same applies to obstetrics and midwifery: while the subject matter of midwifery and medicine overlap (care of women in pregnancy and childbirth), the distinction between the professions remains.

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

To date, 27 states have joined Delaware in a recognition of the practice of non-nurse midwifery, through licensure, registration, permits, or some other regulatory approach. The Big Push for Midwives, *Big Push for Midwives State Regulation PushChart* (May 17, 2013), http://pushformidwives.org/wp-content/uploads/2013/05/Push-for-Midwives-State-Regulation-PushChart_MAY-2013.pdf. None of these 28 states have repealed these laws. *Id.* In most of these states, including Delaware, the CPM (Certified Professional Midwife) credential provides the basis for qualification. As is the case in Delaware, authority and oversight for the practice of midwifery does not reside with the board of medicine,

but rather with the state's department of public health or other regulatory board. *See* 16 *Del. C.* 122(3)(h).

II. The Legislature Authorized the Practice of Non-nurse Midwifery.

While the state's case portrays Appellant as resisting the authority of the Medical Practices Act, in reality, the Board of Medicine, the DHSS and the trial court are resisting the intent of the legislature: the Board and the trial court have disregarded the very clear statutory and regulatory scheme that currently exists regarding midwives, and the rules that make compliance impossible.

A. The Delaware Legislature Created a Clear Path for Non-Nurse Midwifery.

The authorizing statute for the practice of non-nurse midwifery, 16 *Del. C.* § 122(3)(h), recognizes it as a distinct profession and orders the Department to promulgate rules for non-nurse midwifery practice and to issue practice permits. 16 *Del. Adm. C.* § 4106. The statute does *not* confer any authority upon the Board of Medical Licensure and Discipline (BMLD); in fact, there is no mention of that body. When the statute so clearly offers a course of action for exactly the circumstance that this case presents, seeking jurisdiction from another authority is not justified.

The state tried to justify its pursuit of Appellant, *see* Appellant's Opening Br. 10-11, by claiming that the BMLD holds authority over un-permitted midwives

simply because there exists an overlap in scope of practice between medicine and non-nurse midwifery. This argument is invalid for the following reasons.

First, the provisions of the Medical Practices Act that designate authority over professions *other than medicine* clearly specify that those professions must be "regulated by this chapter." 24 *Del. C.* §§ 1710(a), 1713. Such professions must be named, the statute does not allow the regulating board to *infer jurisdiction* over other professions.

Second, in a 2012 case the Court deferred to the primary legislative intent of a statute invoking the principle of statutory construction, *expressio unius est exclusio alterius. Avila-Hernandez v. Timber Prods.*, No. N10A-06-002 DCS, 2012 WL 1409538, at *13-15 (Del. Super. Ct. Jan. 6, 2012). It also held that a state agency could not impose contrary language in a regulation "without causing a forfeiture of rights expressly conferred in a state statute." *Id.*

Finally, the statute *explicitly* confers jurisdiction on DHSS to penalize non-permitted midwives. 16 *Del. C.* § 107; 16 *Del. Adm. C.* § 4106 (8.0-9.0). The presence of this explicit language invokes the Delaware judiciary's plain language construction. *Ins. Comm'r of Del. v. Sun Life Assurance Co.*, 21 A.3d 15, 20 (Del. 2011). The Medical Practice Act does not include non-nurse midwifery in its jurisdiction, while another statute explicitly confers this jurisdiction on DHSS.

B. DHSS Enacted Rules that Essentially Made Compliance Impossible.

DHSS has exclusive authority to regulate non-nurse midwives. The Legislature has chosen to permit practice by non-nurse midwives and, to that end, in 2002 DHSS established a $100 fine as the penalty for practicing without a permit. 16 *Del. Adm. C.* § 4106 (9.0). Appellant would accept this penalty since it was impossible to qualify for a permit under the rules that require a collaborative agreement with a physician. 16 *Del. Adm. C.* § 4106 (3.0).

Requiring midwives to obtain agreements from obstetricians – *their competitors* – would be like requiring Costco to get permission from Walmart to open a new store. No other state requires such collaboration agreements, and the Federal government prohibits them. That this requirement is unfair and unworkable is evidenced by the fact that only one non-nurse midwife has been able secure such an agreement since the requirement went into effect in 2002, and only with the express limitation that she exclusively serves Amish communities. *See, e.g.*, Emily Crockett, *Midwives Fight to Make Their Practice Legal Again in Delaware*, RH Reality Check (May 8, 2014, 1:36 PM), http://rhrealitycheck.org/article/2014/05/08/midwives-fight-make-practice-legal-delaware/ [hereinafter Crockett].

The current administrative rules, by requiring formal collaborative practice agreements with physicians, effectively preclude non-nurse midwives from

obtaining the permits that would confer legal status. *See id.* Physicians are unlikely to sign such an agreement with a midwife if they will be excluded by professional liability insurers like the Medical Society of Delaware Insurance Services, Inc., *a wholly-owned subsidiary of the Medical Society of Delaware*, who refuse to offer coverage to physicians who contemplate collaborating with non-nurse midwives. Motion to Recuse, Appellant's App., Tab 97, A95-96.

It is worth noting that of the 27 states that legally authorize CPMs to practice, Delaware is the only state that presently requires a collaboration agreement. Midwives Alliance of North America, *State by State*, http://mana.org/about-midwives/state-by-state#Delaware. The current rule makes it impossible for non-nurse midwives to obtain permits to practice. *See* Crockett, *supra*. This systemic practice is questionable in a state where maternal and child health markers indicate a strong need for access to midwifery care.

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

Midwifery-led care--both in and out of hospitals--is universally acknowledged as resulting in fewer complications and overall better maternal and infant health outcomes. *See, e.g.*, Jane Sandall et al., *Midwife-led continuity models versus other models of care for childbearing women*, The Cochrane Collaboration (Aug. 21, 2013).

This year, the World Health Organization (WHO), recognizing midwives as the appropriate primary caregivers for pregnant women around the world, issued a call to action urging countries to, "Champion midwifery and ensure all women have access to these services," "Provide first-level midwifery close to the woman and her family, with seamless transfer to next-level care when needed," "Support regulation and legislation for midwifery practice," and "Develop and implement midwifery licensing, with continued education and renewal requirements." World Health Org., *Fact Sheet: The State of the World's Midwifery 2014* 2-3 (2014), http://www.unfpa.org/sites/default/files/resource-pdf/Fact%20Sheet_SoWMy%20-%20FINAL%20-%20May%2029%202014%20%281%29.pdf.

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

The WHO and the American Public Health Association (APHA) recognize the legitimacy of, and advocate for the increased access to, direct-entry midwives like CPMs. *See* World Health Org., *The State of the World's Midwifery 2014*, at 3 (2014); American Public Health Association, *Increasing access to out-of-hospital maternity care services through state-regulated and nationally-certified direct-entry midwives*, 92 Am. J. Pub. Health 453-55 (2002). CPMs like the Appellant are the only category of midwives who are specifically trained to attend normal, healthy births in out-of-hospital settings like homes and birth centers. Extensive hands-on experience is mandatory for certification, and CPM training is designed

to support the "remarkable competence" of the mother-baby dyad. *See* Carol Sakala & Maureen P. Corry, *Evidence-Based Maternity Care: What It Is and What It Can Achieve*, Childbirth Connection, 25 (2003), http://www.milbank.org/uploads/documents/0809MaternityCare/0809MaternityCare.pdf.

These recommendations are no less important to first-world countries like the U.K. and the U.S. This month, in line with WHO recommendations, the U.K.'s National Institute for Health and Care Excellence (NICE) released national guidelines advising that 45% of women (healthy and at low risk for complications) would be *safer* in midwife-led, out-of-hospital birth settings, with no additional risk to their babies. Katrin Bennhold & Catherine Saint Louis, *British Regulator Urges Home Births Over Hospitals for Uncomplicated Pregnancies*, N.Y. Times, Dec. 3, 2014, http://www.nytimes.com/2014/12/04/world/british-regulator-urges-home-births-over-hospitals-for-uncomplicated-pregnancies.html?_r=0.

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

1311-19 (2007). Ten years ago, women were less likely to die of maternal mortality in 33 other countries. *Id.*

Four years ago, Amnesty International called American maternity care a "crisis." *See* Amnesty International, *Deadly Delivery: The Maternal Health Care Crisis in the USA: One Year Update* (2011) [hereinafter *Deadly Delivery*]. This year, a study published in the medical journal The Lancet revealed the U.S. is one of only eight countries in the world with a rising maternal mortality rate over the last ten years. Carol Morello, *Maternal deaths in childbirth rise in the U.S.,* Wash. Post, May 2, 2014, http://www.washingtonpost.com/local/maternal-deaths-in-childbirth-rise-in-the-us/2014/05/02/abf7df96-d229-11e3-9e25-188ebe1fa93b_story.html. These poor outcomes persist, despite the fact that the U.S. outspends every other country on its maternal health care delivery system, with spending reaching $98 billion annually. *See Deadly Delivery*, *supra*, at 3. Feeding into that cost is the fact that surgical specialists (obstetricians), rather than cost-effective midwives, attend over 90% of all births in the U.S. Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. Times, June. 30, 2013, http://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?pagewanted=all&_r=1&.

The U.S. deviates from international practice around midwifery, some states going so far as to criminalize midwives. *See* Jennifer Block, *Pushed: The Painful*

Truth about Childbirth and Modern Maternity Care 213 (2007) ("The United States is the only country to have made the modern home-birth midwife an outlaw.") Delaware and the mid-Atlantic region, specifically, demonstrate an ongoing need to improve maternity care, as maternity wards close and C-section rates skyrocket due to factors other than patient need. Ann L. Rappoport, *The Maternity Unit Dilemma*, MetroKids (Jan. 2010), http://www.metrokids.com/MetroKids/January-2010/The-Maternity-Unit-Dilemma/. Meanwhile, Delaware's patient pool is likely to expand as a result of the state's Medicaid expansion under the Affordable Care Act. *See, e.g.*, The Henry J. Kaiser Family Foundation, *How Will the Uninsured in Delaware Fare Under the Affordable Care Act?* (2014), http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-delaware/. As supply dwindles, the demand for trained, skilled attendants for out-of-hospital birth has increased dramatically on a national level over the last ten years. Marian F. MacDorman et al., *Trends in Out-of-Hospital Births in the United States, 1990-2012*, 144 Nat'l Ctr. Health Stat. Data Brief (March 2014), http://www.cdc.gov/nchs/data/databriefs/db144.pdf.

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

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

Midwives like Ms. Webster are forced underground when the state regulatory scheme fails to recognize midwifery as distinct from medicine, fails to enact the will of the legislature, and makes it impossible for qualified midwives to obtain a permit. When this happens the families of Delaware suffer. They face a lack of legitimate health care options that is unparalleled in the world, and should be unheard of in a country as well-resourced as the United States.

Paul Burcher, M.D. PhD, an obstetrician/gynecologist, fellow of the American College of Obstetricians and Gynecologists, and Assistant Professor of

Bioethics and Obstetrics and Gynecology at the Alden March Bioethics Institute of Albany Medical College, whose obstetric practice "embrace[s] a model of informal collaboration" with their midwife colleagues. Paul Burcher, *What's an Ethical Response to Home Birth?*, ObGyn.net (Dec. 4, 2014), http://www.obgyn.net/whats-ethical-response-home-birth. He asserts that, based on his experience, the experiences of his physician colleagues, and the example of the Netherlands model, the safety of home birth is maximized by treating it as "a reasonable option that some women will choose." *Id.* The ethical professional responsibility of physicians, he says, "must include supporting all of the birth options women have and to make each as safe as possible." *Id. We argue the same is true for the state.*

CONCLUSION

For the foregoing reasons, we affirm that it is particularly important to manifest fair, even-handed regulatory systems and due process that do not constrain the fundamental right of women to choose the circumstances in which they give birth. In the present case, the court should affirm the role of midwifery in Delaware's health care system by recognizing that the Appellant was not practicing medicine without a license, but was practicing midwifery under the jurisdiction of Delaware's public health department.

Respectfully submitted,

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DATED: December 19, 2014