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Seeking Safety While Giving Birth During the Pandemic

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SEEKING SAFETY WHILE GIVING BIRTH DURING THE PANDEMIC

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ABSTRACT

As COVID-19 spread throughout the United States in early 2020, many pregnant people sought alternatives to delivering in a hospital. Midwifery practices offering services at home or in a freestanding birth center reported record numbers of inquiries, including from people looking to transfer care near the end of pregnancy. Whether due to fear of COVID-19 exposure in health care settings or out of a desire to avoid restrictive hospital policies regarding support people and newborn separation, people who had not previously considered home birth were newly drawn to midwifery care and others who had considered a midwife-attended birth redoubled their efforts to find an available provider. The turn to community birth—birth in a freestanding birth center or at home, usually with the support of a midwife—is a reasonable and understandable development, given the strong health and safety record of midwifery care, midwifery's focus on holistic and individualized care, and the generally smaller caseload size of midwifery practices relative to obstetrics practices, which can minimize the number of people to whom providers are exposed during a health crisis. Midwifery care is especially attractive for some pregnant people of color—and Black women in particular—who have experienced bias and discrimination in health care settings and who have higher rates of both provider mistreatment and adverse health outcomes than White women in mainstream maternity care. But many pregnant people who sought midwifery care during the pandemic discovered they lacked access to non-hospital-based alternatives, as the supply of local midwives could not meet demand or legal restrictions meant there simply were no midwives in the area.

This Article examines the turn to community birth during the COVID-19 pandemic and argues that various legal and regulatory restrictions on

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midwifery practice unfairly interfere with access to this important, health-promoting model of care, especially for people of color, who disproportionately bear the burden of poor maternal health outcomes and hospitalization or death from COVID-19. In particular, this Article examines how lack of licensure for direct-entry midwives in some jurisdictions, along with non-evidence-based restrictions on scope of practice for all types of midwives and burdensome regulatory hurdles to establishing freestanding birth centers, impedes the growth of midwifery as a profession and limits access to community birth. This Article concludes with several recommendations that draw on the experiences of pregnant people during the pandemic to advance a pro-midwifery reform agenda that will tackle inequities in access to community birth and improve maternity care for all.

I. INTRODUCTION

Pregnant people are bombarded with advice about how to prepare for labor, delivery, and the transition to parenthood.[1] But for millions of people who were pregnant in March 2020, or who became pregnant in the subsequent months—as the United States began to grapple with the fast-spreading COVID-19 virus—there was nowhere to turn for time-tested advice about how to navigate childbirth during a global pandemic. The uncertainties surrounding COVID-19's impact on pregnancy and childbirth not only created anxiety and stress for prospective parents but also left health care providers to adjust their policies regarding prenatal, intrapartum, and postpartum care without evidence about best practices to protect the health and safety of pregnant people and their babies. When pregnant people sought alternatives to hospital birth in order to minimize the risk of COVID-19 exposure and increase their feelings of safety, many found they lacked access to community birth supported by midwives, whether at home or at a freestanding birth center.[2] Some people discovered their local midwifery practices were operating at or over capacity; others learned they lived in a community-birth desert with no local midwives, whether due to burdensome legal restrictions, hostility from area medical providers, or both.[3] Existing

1. In certain places, this Article refers to people seeking pregnancy and childbirth care as women, but it is important to recognize that some men and non-binary people also experience pregnancy and childbirth. *See, e.g.*, Robin Marantz Henig, *Transgender Men Who Become Pregnant Face Social, Health Challenges*, NPR (Nov. 7, 2014, 3:53 PM), https://www.npr.org/sections/health-shots/2014/11/07/362269036/transgender-men-who-becomepregnant-face-health-challenges. More research is needed on the experiences of transgender individuals seeking maternity care in mainstream health care institutions and the role of midwives in providing culturally appropriate care for transgender and gender non-confirming pregnant people. *See* Juno Obedin-Maliver & Harvey J. Makadon, *Transgender Men and Pregnancy*, 9 OBSTETRIC MED. 4, 6 (2015) (noting that transgender respondents sought midwifery care at a much higher rate (46%) than the U.S. national average (8.2%)). For accuracy, this Article will use the term "pregnant people" in general discussion and "women" when discussing particular examples or research involving only women, even though the research findings may be applicable to all pregnant people.

2. *See* Kimiko de Freytas-Tamura, *Pregnant and Scared of 'Covid Hospitals,' They're Giving Birth at Home*, N.Y. TIMES (Apr. 24, 2020), https://www.nytimes.com/2020/04/21/nyregion/coronavirus-home-births.html. While childbirth in a freestanding birth center or at home has generally been referred to as "out-of-hospital birth," health care providers attending such births have suggested that "community birth" is a more appropriate term, as it departs from the historical tendency to "reif[y] hospital birth as normative" and "labels the practice for what it is—instead of for what it is not." Melissa Cheyney et al., *Community Versus Out-of-Hospital Birth: What's in a Name?*, 64 J. MIDWIFERY & WOMEN'S HEALTH 9, 9 (2019). This Article will use "community birth" as the default term to refer to birth center and home births together, reserving "out-of-hospital birth" for instances where it is appropriate to emphasize an intention to avoid the hospital.

3. *E.g.*, Freytas-Tamura, *supra* note 2; Meaghan M. McDermott, *Arrest of Midwife Galvanizes Mennonite Community, Highlights Service Desert for Home Births*, DEMOCRAT & CHRON. (Dec. 30, 2018, 1:58 PM), https://www.democratandchronicle.com/story/news/2018/12/30/arrest-midwife-elizabeth-catlin-mennonites-service-desert-home-births/2424187002/.

limitations on choice of birth setting and birth attendant became even more compelling as a growing number of pregnant people felt unsafe going to the hospital.[4]

This Article examines the experience of childbearing people who sought to avoid COVID-19 exposure in hospital settings during the pandemic, paying particular attention to how the paucity of options for community birth harms Black women, along with other vulnerable and marginalized populations. Racial and ethnic minorities have higher rates of COVID-19 infection than White people,[5] and research suggests that the disproportionate burden of adverse health outcomes borne by people of color in this pandemic extends to pregnancy and childbirth.[6] Part I reviews the evidence regarding COVID-19's impact on pregnancy and fetal development, noting the dearth of pregnancy-specific information early in the pandemic. Although the public health and patient-care challenges created by incomplete information about how the virus spreads and its short- and long-term physical consequences are by no means unique to pregnant people, the potential for anxiety and stress to impact fetal development negatively and lead to health complications[7] makes the evidence gaps particularly salient in the childbirth context. In addition, early findings suggest that lockdowns prompted by COVID-19 may impact health outcomes differently depending on socioeconomic status—with wealthier people experiencing health benefits from telecommuting and otherwise staying home, while low-income people face increased risk of adverse maternal and infant health outcomes related to COVID-19 because they cannot isolate due to employment as essential workers, crowded housing, reliance on public transportation, or family care-taking demands.[8]

4. *E.g.*, Freytas-Tamura, *supra* note 2.

5. *See, e.g.*, Daniel Wood, *As Pandemic Deaths Add Up, Racial Disparities Persist—And in Some Cases Worsen*, NPR (Sept. 23, 2020, 1:01 PM), https://www.npr.org/sections/health-shots/2020/09/23/914427907/as-pandemic-deaths-add-up-racial-disparities-persist-and-in-some-cases-worsen (discussing data that show Blacks, Latinos, and Native Americans are hospitalized at rates 4.5 to 5.5 times higher than non-Hispanic Whites and that African Americans die from COVID-19 at 2.4 times the White rate, among other disparities); SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DOUBLE JEOPARDY: COVID-19 AND BEHAVIORAL HEALTH DISPARITIES FOR BLACK AND LATINO COMMUNITIES IN THE U.S. 1 (2020) [hereinafter DOUBLE JEOPARDY]; Tom Avril, *Black, Hispanic Women Infected with Coronavirus 5 Times as Often as Whites in Philly, Penn Study Suggests*, INQUIRER, (July 9, 2020), https://www.inquirer.com/health/coronavirus/coronavirus-covid19-black-hispanic-test-positive-vaccine-update-offit-20200709.html.

6. *See infra* Part II.

7. *See, e.g.*, Michael T. Kinsella & Catherine Monk, *Impact of Maternal Stress, Depression & Anxiety on Fetal Neurobehavioral Development*, 52 CLINICAL OBSTETRICS & GYNECOLOGY 425, 427 (2009).

8. *See generally* Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & BIOSCIENCES 1, 4–7 (2020) (discussing disparities in COVID-19 exposure due to structural racism in employment and housing).

Part II describes the increased demand for alternatives to hospital-based birth during the pandemic to reduce risk and ensure safe and healthy birth experiences. As COVID-19 took hold across the United States, midwives reported an increase in pregnant people seeking their services for community birth.[9] The desire to avoid hospitals amidst a health pandemic is an understandable reaction. Some people sought to avoid the hospital in order to minimize their chances of contracting COVID-19, while others did not want to be subjected to newly implemented risk-reduction policies that would restrict the presence of support people or require separation of newborns from their parents in the event of a positive or suspected COVID-19 test result.[10] Certain risk-reduction strategies employed by obstetrics practices and hospitals disproportionately burden vulnerable populations and may heighten the risk of adverse health outcomes during or after pregnancy.

Part III explains why the turn to midwife-attended community birth is a reasonable and unsurprising choice, given midwifery's positive health and safety record, the individualized attention associated with the midwives model of care, the low-volume practices midwives maintain (relative to obstetrics), and the physical separation of community birth settings from hospitals caring for sick COVID-19 patients, which not only reduces risk of hospital-acquired COVID-19 infection but may also lessen anxiety and associated stress-related health complications for birthing people.[11] Especially for Black women and other pregnant people of color, who are more likely to experience coercion and other forms of mistreatment by their health care providers in hospital settings,[12] the ability to choose community birth during the pandemic is an important exercise of autonomy, as well as a health-protective act. Unfortunately, however, not everyone who wants to deliver outside the hospital with a midwife has access to this model of care.

Part IV identifies how regulatory restrictions on the practice of midwifery and the operation of freestanding birth centers limit opportunities for pregnant people to seek out-of-hospital maternity care. Onerous restrictions on midwives in many jurisdictions, including lack of licensure for Certified Professional

9. *See, e.g.*, Robbie Davis-Floyd, et al., *Pregnancy, Birth and the COVID-19 Pandemic in the United States*, 39 MED. ANTHROPOLOGY 413, 420–21 (2020) (summarizing results of survey among providers about pregnant people's increased interest in community birth due to fear of COVID-19 contagion in hospitals); Sophie Burkholder, *Covid-19 Sparked a Rising Interest in Home Births, but Not All Can Afford Them*, INQUIRER (July 13, 2020), https://www.inquirer.com/news/midwife-midwives-birth-covid-babies-delivery-20200712.html; BrieAnna J. Frank, *As Phoenix-Area Hospitals Limit Labor Patients to 1 Guest, Women Must Pick or Turn to Home Birth*, ARIZ. REPUBLIC (Mar. 25, 2020), https://www.azcentral.com/story/news/local/283rizona-health/2020/03/25/hospitals-restrict-visitors-some-valley-women-turn-home-birth/2909770001/.

10. Freytas-Tamura, *supra* note 2.

11. *See infra* Part IV.

12. Saraswathi Vedam et al., *The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States*, REPROD. HEALTH, June 2019, at 1, 2.

Midwives in fourteen states, have resulted in a limited number of community-based midwives available to care for pregnant people.[13] In non-pandemic times, these restrictions limit consumer choice, interfere with the health-promoting benefits of midwifery, and exacerbate existing health disparities by keeping midwifery care out of reach for many people whose insurance will not cover out-of-hospital birth and who lack the resources to pay out-of-pocket. As COVID-19 has prompted more pregnant people to seek community birth, legal restrictions on midwifery make the lack of access to such care even more acute and the health consequences of that lack of choice even more troubling.

Finally, Part V concludes with several recommendations regarding how to learn from the COVID-19 pandemic to protect the health and safety of all pregnant people in future health crises and continue the necessary work of reforming the U.S. maternity care system by expanding access to midwives and community birth.

II. WEIGHING THE RISKS: DECISION-MAKING WITHOUT DATA

The emergence of COVID-19 in early 2020 left public health authorities scrambling to understand how the virus spreads and impacts those infected.[14] Variations in the symptoms reported and the degree of severity observed in patients who tested positive confounded efforts to develop effective treatments and to advise the public on necessary prevention methods.[15] These problems were especially acute in the maternity care context, where the "public health system's efforts to understand the impact of the coronavirus in mothers and babies have been flat-footed, scattershot and agonizingly slow."[16]

Initial case reports from China offered some early reassurance, indicating that COVID-19 posed no heightened risk to pregnant women, despite the fact that pregnancy strains the immune system.[17] However, this conclusion was

13. *See* Elizabeth Kukura, *Better Birth*, 93 TEMP. L. REV. 243, 281–97 (2021) (describing the constellation of regulatory restrictions faced by different types of midwives and arguing that such restrictions impede progress on improving maternal health outcomes by marginalizing midwives in U.S. maternity care).

14. *See, e.g.*, Daniel B. Jernigan, *Update: Public Health Response to the Coronavirus Disease 2019 Outbreak — United States, February 24, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 216, 216–17 (2020).

15. Allison Snyder, *The Confounding Range of COVID-19 Symptoms*, AXIOS, (July 23, 2020), https://www.axios.com/coronavirus-symptoms-treatment-08574bc0-3a44-4e94-8ba7-f68e31a56f1d.html.

16. Nina Martin, *Agonizing Lag in Coronavirus Research Puts Pregnant Women and Babies at Risk*, PROPUBLICA (July 6, 2020, 5:00 AM), https://www.propublica.org/article/agonizing-lag-in-coronavirus-research-puts-pregnant-women-and-babies-at-risk (quoting an OB-GYN: "'It's shocking to realize that we do not have a uniform system in place' for collecting and analyzing basic maternal and infant health information during times of crisis.").

17. Lian Chen et al., *Clinical Characteristics of Pregnant Women with Covid-19 in Wuhan, China*, 382 NEW ENG. J. MED. e100(1), e100(1) (2020).

based on limited data collected in Wuhan province and was necessarily limited to women in the final trimester of pregnancy due to the recent emergence of the virus.[18] Subsequent efforts to address the gaps in information about COVID-19 and pregnancy have largely relied on physicians reporting findings from other hot spots such as New York City, Seattle, and Chicago, released quickly in the form of case reports without methodological rigor or peer review.[19] Much of this data seemed to conform with the early conclusions from China that many pregnant women remain asymptomatic or suffer only mild symptoms, although it became clear that COVID-19 can manifest as severe illness in some pregnant women.[20] At the same time, there were reports of placental abnormalities,[21] cardiac complications, asymptomatic women whose condition deteriorated after giving birth, and a few cases of suspected "vertical transmission," where babies seemed to contract COVID-19 in utero.[22] This hodgepodge of results produced a confusing landscape where differences in regional and local experiences with the virus shaped clinical understandings.

In mid-May 2020, researchers in the United Kingdom issued results of their study of all 427 pregnant women hospitalized in Britain from March through mid-April who tested positive for COVID-19, concluding that approximately one in ten women required respiratory support, although pregnant women did not seem to become as sick from COVID-19 as they had from H1N1 flu and SARS.[23] The U.K. researchers also found that women of color were more likely than White women to be hospitalized with COVID-19, resulting in new guidance about the heightened risk for women of color.[24] In the United Kingdom, medical groups reaffirmed earlier recommendations that pregnant women in the third trimester should avoid employment settings with increased risk of virus exposure, such as frontline hospital workers caring for COVID-19 patients, which was a marked divergence from American medical organizations that cited a lack of research justifying such practices.[25] Other data emerged outside the

18. *Id.*

19. Martin, *supra* note 16.

20. *Id.*

21. For example, a study released during the last week in May 2020 found a high rate of blood clots and disrupted blood flow to the fetus in the placentas of women who tested positive for COVID-19, even though most of the babies involved in the study were born full-term after normal pregnancies and three quarters of the women were asymptomatic when they were tested for COVID-19 upon hospital admission in labor. *See Placentas from Covid-19-Positive Pregnant Women Show Injury*, SCI. DAILY (May 22, 2020), https://www.sciencedaily.com/releases/2020/05/200522113714.htm. This finding suggested a more complicated picture and the possible need for heightened monitoring of pregnant patients—though the study was based on only sixteen women. *Id.*

22. Martin, *supra* note 16.

23. *Id.*

24. *Id.*

25. *Id.*

United States regarding the relationship between COVID-19 and pregnancy. For example, in June 2020, the World Health Organization (WHO) announced that women were not transmitting COVID-19 through breastfeeding and concluded that the health benefits of breastfeeding outweigh any potential risk.[26]

In late June, after three months of asserting that pregnant women are not at higher risk for COVID-19 complications, the Centers for Disease Control (CDC) updated its guidance to reflect a heightened risk of severe illness for pregnant people.[27] Specifically, the CDC issued new advice that pregnant women with the virus had a fifty percent higher chance of intensive care admission and a seventy percent higher chance of being intubated than their nonpregnant peers.[28] The delay in producing evidence-informed guidelines about risks to pregnant people stems from how data is collected and transmitted to the federal government. The CDC instructs local health departments to indicate on the standard Case Report Form if a patient is pregnant by checking the relevant box; there is also an optional supplemental form that collects information about the severity of the COVID-19 infection, as well as maternal and infant outcomes.[29] Not surprisingly, physicians on the COVID-19 frontlines often do not have time to complete the more robust form, so this data simply is not being collected in a uniform way.[30]

Huge gaps in data collection remain. Existing records lack important health information for approximately three-quarters of pregnant women with COVID-19, including the presence of any preexisting conditions and whether they required admission to the intensive care unit (ICU) or mechanical ventilation.[31] Researchers are unable to identify how many hospitalized pregnant women were admitted due to COVID-19 as opposed to being in the hospital to give birth or for another reason.[32] Notably, for most women of reproductive age who tested positive for COVID-19 by early June—accounting for approximately 326,000 women—there was no information about pregnancy status available.[33] Looking ahead, a number of research teams around the country have launched larger-

26. *Breastfeeding and COVID-19*, WORLD HEALTH ORG. 1, 2 (June 23, 2020), https://www.who.int/news-room/commentaries/detail/breastfeeding-and-covid-19 (noting research detected fragments of the virus but no live virus in breast milk).

27. *COVID-19: People with Certain Medical Conditions: Pregnancy*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html#pregnancy (last updated Feb. 3, 2021).

28. Sascha Ellington et al., *Characteristics of Women of Reproductive Age with Laboratory-Confirmed SARS-CoV-2 Infection by Pregnancy Status — United States, January 22–June 7, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 769, 772, 773 (2020).

29. Martin, *supra* note 16.

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

scale studies of COVID-19 and pregnancy risk, though the results of these efforts will not be available for some time.[34]

Two studies released during the summer of 2020 offered some tentatively hopeful news in the form of lower rates of preterm birth in the early months of the pandemic, meaning fewer low birthweight babies born in need of intensive care, although further research is needed to understand the significance of those findings.[35] Researchers considered possible explanations for the dramatic decline in these critical cases during the COVID-19 lockdown, including that pregnant people experienced less stress while working from home and not commuting, slept more and had greater family support while home, avoided exposure to other viruses, or breathed less polluted air because there were fewer vehicles on the road.[36] All of this, if responsible for the decline in prematurity, could inform post-COVID-19 health policy aimed at maintaining lower rates of preterm birth. But researchers also raised the possibility that some pregnancies that would have resulted in preterm births but for the pandemic actually ended in stillbirth instead of full-term infants.[37] While there does not appear to be a dramatic increase in stillbirths, some studies report more stillbirths than would be expected, though more research is necessary to determine whether this is the result of unidentified COVID-19 infections, pregnant people's reluctance to seek care at the hospital for emerging complications during the pandemic, or some other explanation.[38] It is possible that wealthier people, who remained financially secure and were able to avoid stress by working from home, did

34. Martin, *supra* note 16 (discussing multiple studies by researchers at the National Institute of Child Health and Human Development, UCSF, UCLA). A study presented in January 2021 at a meeting of the Society for Maternal-Fetal Medicine contributed to the knowledge base about pregnancy-related risks with its conclusion that COVID-19 infection during pregnancy is linked to a significantly higher risk of developing gestational hypertension and preeclampsia, compared with remaining free of COVID-19. Tara Haelle, *COVID in Pregnancy Tied to Hypertension, Preeclampsia*, MEDSCAPE (Feb. 2, 2021), https://www.medscape.com/viewarticle/945096#vp_1. Such hypertensive disorders are the most significant cause of maternal and perinatal morbidity and mortality globally. *Id.*

35. Roy K. Philip, et al., *Unprecedented Reduction in Births of Very Low Birthweight (VLBW) and Extremely Low Birthweight (ELBW) Infants During the COVID-19 Lockdown in Ireland: A "Natural Experiment" Allowing Analysis of Data from the Prior Two Decades*, BMJ GLOB. HEALTH, Sept. 2020, at 1, 4; Gitte Hedermann, et al., *Danish Premature Birth Rates During the COVID-19 Lockdown*, 106 ARCHIVES DISEASE CHILDHOOD FETAL & NEONATAL F93, F94–F95 (2021). *See also* Elizabeth Preston, *During Coronavirus Lockdowns, Some Doctors Wondered: Where Are the Preemies?*, N.Y. TIMES (July 19, 2020), https://www.nytimes.com/2020/07/19/health/coronavirus-premature-birth.html (discussing reports of reduced preterm births in other countries after lockdowns to curb COVID-19 spread).

36. *See* Preston, *supra* note 35.

37. Elizabeth Preston, *Did Lockdowns Lower Premature Births? A New Study Adds Evidence*, N.Y. TIMES (Oct. 15, 2020), https://www.nytimes.com/2020/10/15/health/covid-premature-births-lockdown.html.

38. *Id.*

experience fewer preterm births, while low-income people and people of color did not experience the same benefit (or had more pregnancies result in stillbirth).[39] Differences in pregnancy outcome based on socioeconomic status would reflect broader patterns of inequity in the spread and seriousness of COVID-19 itself, though more research is necessary to develop a fuller view of COVID-19's impact on pregnancy.

The uncertainty surrounding COVID-19's potential to harm fetal development and complicate childbirth contributes to heightened stress and anxiety for pregnant people.[40] This is especially true for people whose housing conditions, inability to work from home, or care-taking responsibilities limit the extent to which they can practice strict social distancing.[41] Pregnant people of color already experience worse maternal and infant health outcomes than their White peers, with Black women three to four times more likely to die from pregnancy-related causes,[42] Native women dying at 4.5 times the rate of pregnant non-Hispanic White women,[43] and Black infants suffering disproportionately high rates of low birth weight, prematurity, and mortality.[44] Research suggests that racial health disparities in pregnancy outcomes are driven, at least in significant part, by the corrosive effects of systemic racism in the United States—not by differences in health status before becoming pregnant,

39. *Id.* (noting a Dutch finding that the reduction in preterm births occurred only in wealthier neighborhoods, although the finding was not statistically significant).

40. *See* Meredith Wadman, *Why Pregnant Women Face Special Risks from COVID-19*, SCI. MAG. (Aug. 4, 2020, 3:45 PM), https://www.sciencemag.org/news/2020/08/why-pregnant-women-face-special-risks-covid-19.

41. *See, e.g.*, Thomas D. Sequist, *The Disproportionate Impact of Covid-19 on Communities of Color*, NEW ENG. J. MED.: CATALYST (July 6, 2020), https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0370 (discussing housing and employment conditions of disproportionately hit communities that heighten vulnerability to virus spread).

42. *Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 25, 2020), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html (reporting, based on data submitted to the CDC for 2014–2017, a death rate of 41.7 per 100,000 live births for Black women and 13.4 deaths per 100,000 live births for White women).

43. Mary Annette Pember, *Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support*, REWIRE NEWS GRP. (July 9, 2018, 11:05 AM), https://rewire.news/article/201.8/07/09/amid-staggering-maternal-infant-mortality-rates-native-communities-revive-traditional-concepts-support/.

44. *Infant Mortality*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 10, 2020), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (reporting that infant mortality rates per every 1000 live births were 10.8 for Black babies and 4.6 for White babies in 2018); Joyce A. Martin et al., *Births: Final Data for 2018*, NAT'L VITAL STAT. REP., Nov. 27, 2019, at 1, 29 (reporting higher rates of low birth weight (14.07% versus 6.91%) and preterm delivery (14.13% versus 9.09%) among births to non-Hispanic Black women compared to births to non-Hispanic White women in 2018).

as previously believed.[45] For example, a 2016 study shows that Black college-educated women were more likely to experience severe childbirth-related complications than White women who did not complete high school.[46] A study of five medical complications that cause maternal mortality and morbidity found that Black women were two to three times more likely to die than White women with the same condition, though they did not develop those conditions at a higher rate than White women.[47]

Against this stark backdrop of pregnancy-related racial health disparities, the gaps in knowledge about COVID-19 and pregnancy are significant not only because they keep pregnant people from making the best possible decisions to minimize the risk of harm. In addition, the very state of not knowing what precautions to take generates additional stress and anxiety, which pose concern for the health status of pregnant people and their babies apart from COVID-19 itself[48]—especially for minority populations who are disproportionately contracting and dying from COVID-19.[49]

III. RISK AVOIDANCE: PURSUING HEALTHY BIRTH BY STAYING OUT OF THE HOSPITAL

Rather than face the risk of COVID-19 exposure in the hospital, some pregnant people have sought alternatives to hospital-based birth.[50] In non-

45. *See* Kukura, *supra* note 13 (discussing research on racial health disparities in pregnancy and the link between living with racism and adverse maternal health outcomes that supports Arline Geronimus' "weathering hypothesis").

46. N.Y.C. DEP'T OF HEALTH & MENTAL HYGIENE, SEVERE MATERNAL MORBIDITY 15 (2016).

47. Myra J. Tucker et al., *The Black-White Disparity in Pregnancy-Related Mortality from 5 Conditions: Differences in Prevalence and Case-Fatality Rates*, 97 AM. J. PUB. HEALTH 247, 249 (2007).

48. Erika Edwards, *Pregnant in a Pandemic: How COVID-19 Stress May Affect Growing Babies*, NBC NEWS (Aug. 16, 2020, 3:30 AM), https://www.nbcnews.com/health/health-news/pregnant-pandemic-how-covid-19-stress-may-affect-growing-babies-n1236372 (reporting that stress during pregnancy has been linked to negative impacts on fetal brain development, and that researchers saw a marked increase in the stress levels of pregnant women during the onset of the COVID-19 pandemic).

49. *See* DOUBLE JEOPARDY, *supra* note 5 (noting that Black people comprise only thirteen percent of the total U.S. population but account for thirty percent of COVID-19 cases and suffer disproportionately high COVID-19 deaths rates as well).

50. Burkholder, *supra* note 9; Abigail Abrams, *Amid Social Upheaval and COVID-19, Black Women Create Their Own Health Care Support Networks*, TIME (July 17, 2020, 3:10 PM), https://time.com/5866854/black-women-health-care/ (quoting a midwife in Memphis, Tennessee, who "has been flooded with calls and social media messages every day for months" (quotation marks omitted)); Freytas-Tamura, *supra* note 2 (reporting a thirteen-fold increase in inquiries to Brooklyn birth centers from before the pandemic). In addition, some pregnant people in COVID-19 hotspots migrated to geographic areas experiencing lower rates of the virus, increasing the burden on maternity care providers. *See* Wendy Ruderman, *Fleeing Coronavirus in NYC, Pregnant*

pandemic times, childbearing people and newborns comprise a significant percentage of the people seeking care at hospitals, representing twenty-three percent of all people discharged from hospitals—even though they are not sick.[51] Scholars and advocates have identified dissonance in the fact that U.S. maternity care is so concentrated in hospitals, with their high concentration of disease, critiquing the medicalization of childbirth in the United States and the degree to which birth is treated as an illness to be managed rather than a normal, physiologic process.[52] Reliance on hospitals for childbirth-related care takes on added risk during a health crisis like the COVID-19 pandemic, as it brings healthy pregnant people in proximity to a higher concentration of people who have been exposed and infected.[53]

Some pregnant people sought to avoid hospital-based birth due to a generalized fear of exposure to the virus during a hospital stay.[54] In particular, the desire may have reflected a concern that hospitals were inadequately prepared to segregate healthy pregnant people from pregnant people infected with COVID-19, in part because staff continued to alternate between care for COVID-19-positive and negative patients.[55] For others, the risk-reduction

Women Head to Philly Area but Struggle to Find Prenatal Care, PHILA. INQUIRER (Apr. 2, 2020), https://www.inquirer.com/health/coronavirus/coronavirus-pregnant-new-york-brooklyn-media-penn-obstetrician-main-line-health-20200403.html (quoting Philadelphia midwife discussing an "unprecedented" volume of calls from women seeking to transfer care to a homebirth midwife (quotation marks omitted)).

51. CAROL SAKALA & MAUREEN P. CORRY, EVIDENCE-BASED MATERNITY CARE: WHAT IT IS AND WHAT IT CAN ACHIEVE 2 (2008).

52. ROBBIE E. DAVIS-FLOYD, BIRTH AS AN AMERICAN RITE OF PASSAGE 38, 278 (2d ed. 2003); Elizabeth Kukura*, Obstetric Violence*, 106 GEO. L.J. 721, 769–70 (2018); *Infographic: The Overmedicalization of Childbirth*, CAL. HEALTH CARE FOUND. (Sept. 12, 2018), https://www.chcf.org/publication/infographic-overmedicalization-childbirth/; *Over-Medicalization of Maternal Health in America*, EVERY MOTHER COUNTS (Sept. 11, 2014), https://blog.everymothercounts.org/over-medicalization-of-maternal-health-in-america-40e20e6b4171. *See also* NAT'L ACADS. OF SCIS., ENG'G, AND MED., BIRTH SETTINGS IN AMERICA: OUTCOMES, QUALITY, ACCESS, AND CHOICE 13 (2020) (noting that American maternity care "relies primarily on a surgical specialty to provide front-line care, [even though] most childbearing women are largely healthy and do not need that type of care in first-line providers").

53. Freytas-Tamura, *supra* note 2 (discussing a New York hospital's advice to a pregnant person to avoid coming in and risking exposure during a checkup, as the hospital was experiencing a surge of COVID-19 infections).

54. *Id.* (noting a demand for non-hospital births, not because pregnant people do not want to be in hospitals but rather because "they don't want to be in a Covid hospital" (quotation marks omitted)).

55. *See* Ruth Cummins, *Caring for COVID-19-Positive Moms a Labor of Love*, U. MISS. MED. CTR. (July 20, 2020), https://www.umc.edu/news/News_Articles/2020/07/COVID-Labor-and-Delivery.html ("We have all of our other high-risk moms. We're doing it all on the same unit." (quotation marks omitted)); Betty-Anne Daviss et al., *Pivoting to Childbirth at Home or in Freestanding Birth Centers in the US During COVID-19: Safety, Economics and Logistics*, FRONTIERS SOCIO., Mar. 2021, at 11, https://www.frontiersin.org/articles/10.3389/fsoc.2021.618

strategies adopted to limit the spread of COVID-19 in hospitals interfered with their decision-making in ways they perceived would threaten their ability to deliver safely and securely.[56]

For example, some hospitals adopted restrictive visitor policies that prevented pregnant people from having doula support or, in some instances, required them to deliver alone without any family member present.[57] Hospitals also separated newborns from their parents in the presence of a positive or suspected COVID-19 result on the basis of limited evidence regarding intrapartum or postpartum transmission.[58] These risk-reduction strategies negatively alter the environment for all pregnant people, but they especially increase the burdens borne by vulnerable populations and may increase the risk of non-COVID-19-related adverse health outcomes during or after the pregnancy.[59]

210/full (noting that anesthesiologists and nurse anesthetists are the "true wild cards in the hospital" when it comes to risk of COVID-19 exposure, given how rapidly they may move between intubating a COVID-19 patient and placing an epidural for a laboring person).

56. *See id.* (describing how pregnant people who test positive for COVID-19 often worry more about laboring alone and being separated from their babies than about being sick); Davis-Floyd et al., *supra* note 9, at 421 (noting that women who switched to home birth from a hospital-based nurse-midwifery practice were motivated by "fear of losing their doula support" rather than fear of COVID-19 exposure).

57. For discussion of the role of doulas in childbirth, see *infra* Part III.A.

58. Adrianna Rodriguez, *'Heartbreaking': Moms Could Be Separated from Their Newborns Under Coronavirus Guidelines*, USA TODAY (Mar. 26, 2020, 12:26 PM), https://www.usatoday.com/story/news/health/2020/03/26/pregnant-women-covid-19-could-separated-babies-birth/2907751001/ (discussing hospitals following the CDC's recommendation that newborns be separated from their COVID-19 positive mothers for three to fourteen days, despite the lack of information regarding transmission risks).

59. *See* Seema Mohapatra, *Reproductive Injustice and COVID-19*, HARV. L. & POL'Y REV., https://harvardlpr.com/2020/07/21/reproductive-injustice-and-covid-19/ (last visited Feb. 13, 2021) (detailing how hospitals' restrictive companion policies disproportionately impact pregnant people of color, who are already statistically more likely to die from a pregnancy-related issue than White individuals). There have also been reports from outside the United States of hospitals mandating certain obstetrical interventions for people delivering in the facility regardless of medical necessity. HUM. RTS. IN CHILDBIRTH, HUMAN RIGHTS VIOLATIONS IN PREGNANCY, BIRTH AND POSTPARTUM DURING THE COVID-19 PANDEMIC 11–12 (2020) [hereinafter HRIC REPORT] (discussing mandated epidurals, inductions, and cesarean deliveries); Katie Griffin, *Almonte Hospital Requesting Pregnant Women Get Epidurals Amid COVID-19*, CTV NEWS (Apr. 10, 2020, 6:09 PM), https://ottawa.ctvnews.ca/almonte-hospital-requesting-pregnant-women-get-epidurals-amid-covid-19-1.4891727 (discussing an Ottawa hospital that issued a memo stating, "we are requesting that all patients have an epidural," followed by a subsequent hospital statement indicating that patients declining the epidural would have to deliver at another facility). After midwives intervened, the hospital indicated that the epidural policy was a request and not a requirement, and people would not be turned away for declining an epidural. *Id.*

Providers claim COVID-19 risks justify such interventions in order, for example, to avoid general anesthesia, including intubation, in the event an emergency cesarean is necessary or to ease the burden on medical staff. *See, e.g.*, HRIC REPORT, *supra*, at 11 (detailing how some Canadian

This Part describes in greater detail how risk-reduction strategies adopted by hospitals may interfere with certain pregnant people's ability to birth safely and securely or negatively impact postpartum maternal and infant well-being. By explaining how these policies depart from evidence-based maternity care practices and increase the risk of adverse health outcomes, the discussion illustrates how such mechanisms may increase the vulnerability of certain pregnant people, especially pregnant people of color.

A. Restrictive Companion Policies

To limit the spread of COVID-19, hospitals enacted restrictions on third parties accompanying pregnant patients for obstetric care.[60] The most extreme version of these policies, adopted by New York City-area hospitals during the city's first wave of infections in March 2020, prohibited all companions—meaning that birthing people were alone for labor and delivery, supported only by nurses stretched thin by COVID-19-related staff shortages.[61] Being forced to

hospitals required epidurals in order to limit providers' exposure to aerosol-producing procedures, such as the administration of general anesthesia). Although use of induction, epidural, and cesarean surgery is common during childbirth, they are not risk-free interventions and, in the absence of medical necessity, they may needlessly increase the risk of adverse health outcomes. *See* SAKALA & CORRY, *supra* note 51, at 37–39, 43–46 (discussing maternal and fetal/infant risks of induction, epidural analgesia, and cesarean surgery).

I am unaware of any U.S. hospitals mandating obstetrical interventions as a COVID-19-risk management strategy, though some hospitals have changed their policies on whether and when to recommend interventions such as induction and early epidural placement in ways that patients may fear will interfere with their ability to control their own medical decision-making. *See, e.g.*, Sonja Sharp, *Pregnant Women Forced to Get Creative as Coronavirus Bears Down on L.A. Hospitals*, L.A. TIMES (Apr. 1, 2020), https://www.latimes.com/california/story/2020-04-01/coronavirus-labor-delivery-los-angeles-hospitals (discussing a large hospital network in California that began offering early inductions due to COVID-19). It is possible that concern about pressure to accept unwanted interventions during a hospital birth may have contributed to the increased interest in community birth as the pandemic unfolded.

60. Ruderman, *supra* note 50 (discussing restrictions in New York City hospitals that left "women sobbing as their partners dropped them off at the hospital lobby doors"). New support person restrictions also applied to many in-person prenatal appointments such as ultrasounds or monitoring of patients with high-risk pregnancies. *See, e.g.*, *COVID-19 & Pregnancy: What You Need to Know*, KAISER PERMANENTE, https://healthy.kaiserpermanente.org/health-wellness/maternity/healthy/covid-19-and-pregnancy (last visited Feb. 13, 2021) (informing patients that they must attend prenatal appointments alone in light of COVID-19 restrictions).

61. Ruderman, *supra* note 49. *See also* Irin Carmon, *More Hospitals Are Banning Partners from Delivery Rooms*, THE CUT (Mar. 23, 2020), https://www.thecut.com/2020/03/delivery-room-visitor-bans-are-confusing-patients.html (discussing New York hospital restrictions on support people, including New York Presbyterian Hospital's adoption of a companion ban on March 23, 2020, followed by Mt. Sinai's ban, adopted on March 24, 2020). On March 28, 2020, after public outcry, New York Governor Andrew Cuomo issued an executive order requiring hospitals to allow one fever-free support person as a condition for maintaining licensure. Exec. Order No. 202.12, Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency,

labor alone may lead birthing people to experience increased stress and trauma during a vulnerable period, which is made even more acute by the fear of contracting COVID-19 while in the hospital.[62] Elsewhere, hospitals limited patients to one support person during labor and delivery, which generally meant that birthing people had the support of a partner or spouse but not a doula or any other family member.[63]

For someone who intended to give birth with doula support, the absence of this resource can be significant, depriving the birthing person of a trusted companion who has both experience with childbirth and personal knowledge of the birthing person's circumstances—unlike labor and delivery nurses, who have the former but not the latter, and are responsible for monitoring multiple laboring people at any given time.[64] Birth doulas are non-medical support people who provide culturally appropriate emotional, physical, and informational support during pregnancy and childbirth.[65] Research links continuous doula support during childbirth with less complicated deliveries and lower rates of cesarean surgery, all of which lead to easier recoveries and fewer postpartum complications.[66] The medicalization of maternity care in the United States—

State of N.Y. *See infra* notes 87, 89–91 and accompanying text for discussion of the circumstances surrounding the change in policy and subsequent updates.

62. *See* Freytas-Tamura, *supra* note 2 (discussing how restrictions on support people discourage some pregnant individuals from seeking a hospital birth due to a desire to be around their families and a fear of COVID-19 in hospitals).

63. Emily Bloch, *Coronavirus: New Sparked Interest in Home-Births Amid Hospital Restrictions*, THE FLA. TIMES-UNION (May 1, 2020, 3:38 PM), https://www.jacksonville.com/story/news/local/2020/05/01/coronavirus-new-sparked-interest-in-home-births-amid-hospital-restrictions/112278276/ (noting that Jacksonville, Florida-area hospitals limited birthing people to one visitor).

64. *See* Molly Porth Cabrera, *Facts and Myths: The Doula*, THE FAM. PRAC. & COUNSELING NETWORK (May 18, 2020, 9:16 AM), https://www.fpcn.com/facts-and-myths-the-doula/.

65. *What is a Doula?*, DONA INT'L, https://www.dona.org/what-is-a-doula/ (last visited Mar. 24, 2021).

66. Megan A. Bohren, et al., *Continuous Support for Women During Childbirth*, 7 COCHRANE DATABASE SYSTEMATIC REVS. at 1, 4–5 (2017) (finding people with doula support had a thirty-nine percent decrease in likelihood of cesarean delivery and fifteen percent increase in likelihood of spontaneous vaginal birth). Continuous labor support is also associated with a decreased reliance on medication pain relief, shorter labors, better newborn Apgar scores, and increased satisfaction with the birth experience. *See* Rebecca Dekker, *Evidence on: Doulas*, EVIDENCE BASED BIRTH, https://evidence basedbirth.com/the-evidence-for-doulas/ (last updated May 4, 2019) (summarizing systemic review for lay audience). Doula support also reduces the burden on nursing staff, who are facing increased demands on their time during the pandemic, and reduces length of hospital stay, which reduces COVID-19 exposure risk. *See* Amy Elliott Bragg, *A Doula Fights to Support Families Giving Birth During the Pandemic*, CRAINS DETROIT BUS. (May 17, 2020, 5:46 AM), https://www.crainsdetroit.com/covid-19-heroes/doula-fights-support-families-giving-birth-during-pandemic.

with nearly one in three deliveries resulting in a cesarean[67] and high rates of other interventions during labor and delivery[68]—has not curbed the country's current maternal mortality crisis and, in fact, may be contributing to unnecessary morbidity and mortality.[69] Doula support is an effective tool for avoiding excessive intervention during childbirth, so when hospital COVID-19 policies preclude in-person doula care, patients are deprived of a health-promoting source of support.[70] While insurance coverage of doula services remains limited, doulas are not a luxury only wealthy women seek, as they are sometimes characterized.[71] With increasing recognition of the value doula support provides, some states have moved to establish Medicaid coverage for doula services.[72] In addition, non-profit and community-based organizations across the country have established programs to make doula services available at no or low cost to pregnant people who are otherwise unable to pay their fees.[73]

67. *See* Joyce A. Martin et al., *Births: Final Data for 2016*, 67 NAT'L VITAL STATS. REPS., Jan. 31, 2018, at 40 tbl. 17 (reporting that 31.9% of babies born in the United States in 2016 were by cesarean).

68. *See* EUGENE R. DECLERCQ ET AL., LISTENING TO MOTHERS III: PREGNANCY AND BIRTH XI–XII (2013) (summarizing data regarding the frequent use of various interventions during childbirth).

69. *See* Anita Slomski, *Why Do Hundreds of US Women Die Annually in Childbirth?*, 321 JAMA 1239, 1239 (2019).

70. *See* Carmon, *supra* note 61 (interviewing New York-based doula about concerns that without support from a partner or doula, "marginalized patients would suffer the most"). Some doulas have adapted to COVID-19 conditions by introducing virtual support for birthing people over the phone or by smartphone or tablet. *Id.* (noting "free-or-pay-what-you-can virtual doula services" for those impacted by companion restrictions). *See also* Gray Chapman, *'A Lifeline: The Doulas Guiding Clients Through Childbirth—From a Distance*, THE GUARDIAN (Apr. 22, 2020, 1:00 PM), https://www.theguardian.com/lifeandstyle/2020/apr/22/doulas-childbirth-coronavirus-pandemic. While virtual doula support is certainly better than no support at all, the lack of physical presence is an impediment to providing all forms of care and support doulas are equipped to offer. *Id.* In addition, some patients have reported being restricted from communicating with their doula by videoconference under existing hospital policies that forbid recording devices in the delivery room out of a concern for malpractice exposure. *See* Katharine Q. Seelye, *Cameras, and Rules Against Them, Stir Passions in Delivery Rooms*, N.Y. TIMES (Feb. 2, 2011), https://www.nytimes.com/2011/02/03/us/03birth.html. Advocates criticize such policies and their implications under the COVID-19 restrictions as violations of patients' rights. *Id.*

71. *E.g.*, Miriam Zoila Perez, *By Comparing Doulas to Amazon Prime, the New York Times Seriously Minimizes Our Impact*, REWIRE NEWS GRP. (Feb. 20, 2015, 4:10 PM), https://rewirenewsgroup.com/article/2015/02/20/comparing-doulas-amazon-prime-new-york-times-seriously-minimizes-impact/.

72. *E.g.*, *New York State Doula Pilot Program*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/redesign/doulapilot/index.htm (last visited Feb. 19, 2021).

73. *See e.g.*, ASTEIR BEY ET AL., ADVANCING BIRTH JUSTICE: COMMUNITY-BASED DOULA MODELS AS A STANDARD OF CARE FOR ENDING RACIAL DISPARITIES 9 (2019); Press Release, Governor Phil Murphy, New Jersey Department of Health Exempts Doulas from Hospital Delivery Support Person Limits During COVID-19 (June 29, 2020), https://www.nj.gov/governor/news

In addition to the concrete health benefits of doula support, doulas can help patients advocate for themselves in situations where their health care needs are not being met or where a patient experiences mistreatment by a health care provider, a phenomenon often referred to by advocates as obstetric violence.[74] In particular, where a patient questions or disagrees with the course of treatment recommended by a physician and encounters pressure to consent to unwanted intervention, a doula can help the patient navigate communication with physicians, secure additional information, or identify alternative approaches.[75] There are indications of an increase in reports of mistreatment by health care providers during childbirth since the emergence of COVID-19, including the use of unwanted and medically unnecessary interventions.[76] Despite the lack of evidence that such interventions reduce the risks associated with COVID-19, childbearing people are unable or unwilling to reject these measures due to heightened fear—resulting in "disrespect[] of human dignity" and "long impact effects on maternal and infant mental health."[77] In general, research suggests that people of color, low-income people, and young people disproportionately encounter coercion and other forms of mistreatment by health care providers during childbirth;[78] restrictions on doula support due to COVID-19 concerns put these patients at greater risk of having their rights violated and being subjected to unwanted intervention.[79]

/news/562020/20200629d.shtml (discussing state training of doulas to serve women of color in their own communities); Naima Black & L'Oreal McCollum, *Community-Based Doulas Advancing the Goals of Population Health*, HEALTHY MINDS PHILLY (May 9, 2016), https://healthyminds philly.org/blog/community-based-doulas-advancing-the-goals-of-population-health/ (discussing Philadelphia-based Maternity Care Coalition's community doula training program, which provides free training for doulas to serve their own communities with "culturally and linguistically affirming support" and pairs pregnant women with a community doula at no charge, while providing stipends for doulas matched through the program).

74. *See* Kukura, *supra* note 52, at 727, 800.

75. *Id.* at 759, 779–80.

76. *See* BIRTH RTS. BAR ASS'N, CHALLENGES FACING PREGNANT AND BIRTHING PEOPLE DURING COVID-19, at 2 (Apr. 9, 2020) [hereinafter BRBA REPORT]; HRIC REPORT, *supra* note 59, at 6; Michelle Sadler et al., *COVID-19 as a Risk Factor for Obstetric Violence*, 28 SEXUAL & REPROD. HEALTH MATTERS 46, 47 (2020). In addition, Open Democracy is maintaining a global tracking tool. *See How Has COVID-19 Affected Women's Rights During Childbirth? Help Us Track This Globally*, OPENDEMOCRACY (July 16, 2020), https://www.opendemocracy.net/en/5050 /womens-rights-during-childbirth-help-us-track-globally/.

77. Sadler et al., *supra* note 76.

78. Vedam et al., *supra* note 12, at 8.

79. *See* Mohapatra, *supra* note 59 (suggesting that higher rates of mistreatment for pregnant women of color, compared to White women, underscore the importance of access to in-person support and noting the need to ensure that "protective measures passed with good intentions do not have disparate racial impacts"); Kaia Hubbard, *Pandemic Propels Interest in Out-of-Hospital Births*, U.S. NEWS & WORLD REP. (Mar. 4, 2021) https://www.usnews.com/news/health-news /articles/2021-03-04/pandemic-propels-interest-in-home-out-of-hospital-births (quoting Black woman who chose home birth to avoid hospital restrictions on support people: "In my weakest and

Where hospitals allow for one support person to accompany the pregnant person, they have generally required the support person to remain onsite; once that person has entered the hospital, the desire to limit possible exposure and spread of COVID-19 means he or she will not be permitted to leave and subsequently return for the duration of the patient's admission.[80] Elsewhere, the sole support person has been permitted to be present for the delivery only—excluded from obstetric triage areas—leaving birthing people to labor alone for hours, and the support person has been required to leave the hospital immediately after delivery, again leaving the birthing person alone to begin the recovery process and care for the newborn until they are discharged.[81]

In instances where partners are permitted but cannot leave and return, patients with children at home may have to choose between having their partner available and having someone care for older children, especially given that grandparents, babysitters, and other backup care providers may be unavailable due to COVID-19 social distancing practices.[82] Some patients decide they have no choice but to schedule an induction of labor in order to control the timing of delivery to coincide with available childcare,[83] which is contrary to evidence that suggests waiting for spontaneous labor to begin is generally better for the health of pregnant people and their babies.[84] Restrictive companion policies also

most vulnerable time, I needed folks that I knew could advocate for me as a Black woman and my Black maternal health . . . .").

80. *See* Carmon, *supra* note 61 (describing the policy of twenty-three New York-area hospitals operated by Northwell Health: "There will be no return visitation once leaving the building.").

81. Sharp, *supra* note 59 ("Once the baby is born, new families have just minutes together before the father or partner is asked to leave.").

82. *See* Katherine Harmon Courage, *Day Care, Grandparent, Pod or Nanny? How to Manage the Risks of Pandemic Child Care*, NPR (Aug. 21, 2020, 5:00 AM), https://www.npr.org/sections/health-shots/2020/08/21/902613282/daycare-grandparent-pod-or-nanny-how-to-manage-the-risks-of-pandemic-child-care (describing the challenge of finding childcare during the pandemic, especially as grandparents, nannies, and other caretakers were not available to provide childcare).

83. *See* AGENCY FOR HEALTHCARE RSCH. & QUALITY, THINKING ABOUT HAVING YOUR LABOR INDUCED? A GUIDE FOR PREGNANT WOMEN 3 (Dec. 2009).

84. Debby Amis, *Healthy Birth Practice #1: Let Labor Begin on Its Own*, 23 J. PERINATAL EDUC. 178, 182 (2014). *But see* William A. Grobman, et al., *Labor Induction Versus Expectant Management in Low-Risk Nulliparous Women*, 379 NEW ENG. J. MED. 513, 520 tbl. 3, 522 (2018) [hereinafter ARRIVE study] (reporting that elective induction at 39 weeks did not improve mortality rates or serious complications in infants, although participants who induced at 39 weeks had cesareans at a rate of 19% instead of 22% for the expectant management group, as well as lower rates of preeclampsia/gestational hypertension); Rebecca Dekker, *Evidence on: Inducing for Due Dates*, EVIDENCE BASED BIRTH, https://evidencebasedbirth.com/evidence-on-inducing-labor-for-going-past-your-due-date/ (last updated Feb. 24, 2020) (discussing limitations of the ARRIVE study); Henci Goer, *Parsing the ARRIVE Trial: Should First-Time Parents Be Routinely Induced at 39 Weeks?*, LAMAZE (Aug. 14, 2018), https://www.lamaze.org/Connecting-the-Dots/parsing-the-arrive-trial-should-first-time-parents-be-routinely-induced-at-39-weeks (concluding that contrary to media reports on the ARRIVE study that 39-week induction is preferable to awaiting

impact access to the neonatal intensive care unit (NICU) for families with newborns who need specialized care.[85] While hospitals' risk-reduction strategies impact the care of all patients, they have a disproportionately burdensome impact on low-income patients with less support and fewer options for childcare.[86]

In the wake of hospitals announcing their restrictive companion policies, advocates appealed for state intervention to prevent hospitals from forcing people to labor alone and to restore doula support. In the face of public outcry, some governors issued executive orders targeting hospital companion restrictions.[87] For example, in Michigan, Governor Gretchen Whitmer's March 14, 2020, executive order stated that labor qualifies as an exigent circumstance and clarified that a birthing person may be accompanied by both a partner and doula during labor, delivery, and postpartum, assuming they passed the COVID-19 health evaluation.[88] In New York, Governor Andrew Cuomo's March 28, 2020, executive order required hospitals to "permit the attendance of one support person who does not have a fever at the time of labor/delivery."[89] In a subsequent order issued one month later, Governor Cuomo adopted the recommendations

spontaneous labor, the actual results of the trial yield "far from compelling reasons for routine induction at 39 weeks").

85. Ashley Darcy Mahoney et al., *Impact of Restrictions on Parental Presence in Neonatal Intensive Care Units Related to Coronavirus Disease 2019*, 40 J. PERINATOLOGY 36, 36 (2020) (finding "hospital restrictions have significantly limited parental presence for NICU admitted infants").

86. *See* JAMILLE FIELDS ALLSBROOK, CTR. FOR AM. PROGRESS, THE CORONAVIRUS CRISIS CONFIRMS THAT THE U.S. HEALTH CARE SYSTEM FAILS WOMEN 6 (2020) (discussing the "dire consequences" of hospital visitor restrictions on Black women during childbirth); *see, e.g.*, Sarah Benatar et al., *Improving Prenatal Care and Delivery in the Wake of COVID-19: Lessons from the Strong Start Evaluation*, HEALTH AFFS. BLOG (June 23, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200622.52532/full/ (noting that lack of childcare support was a significant barrier to accessing prenatal care for low-income women who participated in the Center for Medicare and Medicaid Innovation's Strong Start for Mothers and Newborns initiative).

87. *See, e.g.*, Margaret Rodeghier, *How Michigan Doulas Secured Their Position in Hospitals During COVID19 Pandemic*, GROSSE POINT DOULA (Mar. 19, 2020), https://www.professionalbirthsupport.com/post/how-michigan-doulas-secured-their-position-in-hospitals-during-covid19-pandemic; Katie Van Syckle & Christina Caron, *'Women Will Not Be Forced to Be Alone When They Are Giving Birth'*, N.Y. TIMES (Mar. 28, 2020), https://www.nytimes.com/2020/03/28/parenting/nyc-coronavirus-hospitals-visitors-labor.html (noting that a petition opposing hospital restrictions on all support people during childbirth attracted 600,000 signatures).

88. *Executive Order 2020-37 FAQS (No longer effective)*, STATE OF MICH., https://www.michigan.gov/coronavirus/0,9753,7-406-98178_98455-525032—,00.html (last visited Feb. 19, 2021). This followed a March 13, 2020, executive order that had been interpreted to restrict hospital visitors entirely. *See* Bragg, *supra* note 66 (noting that some hospitals did not comply with the second executive order and implemented more restrictive partner-only policies).

89. Exec. Order No. 202.12, Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency, State of N.Y.

of the state's COVID-19 Maternity Task Force,[90] including: (1) extending the time a support person could remain after delivery to include the postpartum recovery period, and (2) clarifying that doulas should be considered an essential part of the care support team and be allowed to accompany a birthing person during labor and delivery in addition to the patient's support person.[91] These policy changes better align hospital practices with research on the health benefits of labor support, though the quickly evolving situation left many pregnant people confused and uncertain about possible future changes.[92]

B. Postpartum Newborn Separation

Another policy change implemented by hospitals focused on the possible risk of maternal-infant transmission and called for separating newborns from their parents in the event of suspected or confirmed COVID-19 infection.[93] Although such separation policies ultimately affected fewer people than the companion restrictions, they raised similar alarm for some pregnant people preparing to deliver in the hospital early in the pandemic.[94]

Public health authorities did not universally agree that separating newborns was the best approach to promoting health and safety. The dearth of evidence about the possibility of vertical transmission of COVID-19 from birthing parents to infants, as well as about the risk COVID-19 poses for infants, resulted in conflicting expert guidance. Following the model instituted by Chinese

90. *See* N.Y. STATE COVID-19 MATERNITY TASK FORCE, RECOMMENDATIONS TO THE GOVERNOR TO PROVIDE INCREASED CHOICE AND ACCESS TO SAFE MATERNITY CARE DURING THE COVID-19 PANDEMIC (2020).

91. *Id.*; Press Release, Secretary to the Governor Melissa DeRosa Issues Report to Governor Cuomo Outlining the COVID-19 Maternity Task Force's Initial Recommendations (Apr. 29, 2020) (stating that Governor Cuomo had accepted the task force's recommendations "in full"). Some medical providers criticized the reversal of companion ban policies, acknowledging the unfortunate impact of the restrictions on birthing people but defending this approach to risk reduction during a critical period of increasing COVID-19 rates. *See, e.g.*, Louise P. King & Neel Shah, *The Ethical Argument Against Allowing Birth Partners in All New York Hospitals*, BILL OF HEALTH (Apr. 8, 2020), https://blog.petrieflom.law.harvard.edu/2020/04/08/new-york-coronavirus-birth-partners/. *But see* Nofar Yakovi Gan-Or, *Going Solo: The Law and Ethics of Childbirth During the COVID-19 Pandemic*, J. L. & BIOSCIENCES, Jan.–June 2020, at 5, 17 (discussing "what laboring people and their families are at risk of losing when they are required to give birth alone" and arguing for legal recognition of the right to birth support).

92. *See* Emily Bobrow, *A Chaotic Week for Pregnant Women in New York City*, NEW YORKER (Apr. 1, 2020), https://www.newyorker.com/science/medical-dispatch/a-chaotic-week-for-pregnant-women-in-new-york-city (noting that continued uncertainty about COVID-19 "helps explain the conflict and confusion" about companion restrictions).

93. Sharp, *supra* note 59.

94. *See* Irin Carmon, *'They Separated Me from My Baby' Hospitals Are Keeping Newborns from Their Parents over Coronavirus Fears.*, THE CUT (Apr. 7, 2020), https://www.thecut.com/2020/04/coronavirus-newborns-hospitals-parents.html.

authorities early in the pandemic,[95] the American Academy of Pediatrics (AAP) recommended separation of newborns from infected mothers, which the AAP later noted was "based on the most cautious recommendation at the time, to minimize neonatal infection while the risk remained unknown."[96] Likewise, the CDC initially recommended separation of newborns until a birth parent with a suspected or confirmed case of COVID-19 was no longer contagious.[97] The World Health Organization (WHO), however, advised that newborns should stay with symptomatic or suspected-positive mothers in order to enable breastfeeding and early bonding, while practicing appropriate hygiene to prevent virus transmission.[98]

Citing the WHO's guidance, experts criticized the AAP and CDC for failing to follow the best-available evidence about breastfeeding and immediate postpartum care.[99] In particular, research supports the importance of the "golden hour" for optimal health outcomes for the maternal-infant dyad.[100] This concept refers to a set of practices immediately after delivery—including delayed cord clamping, skin-to-skin contact for at least an hour, and early initiation of breastfeeding—that enable regulation of the newborn's body temperature, decrease stress levels in both parent and baby, and increase bonding.[101]

95. *See* Jie Qiao, *What Are the Risks of COVID-19 Infection in Pregnant Women?*, 395 LANCET 760, 761 (2020).

96. Alyson Sulaski Wyckoff, *Rooming-In, with Precautions, Now OK in Revised AAP Newborn Guidance*, AAP NEWS (July 22, 2020), https://www.aappublications.org/news/2020/07/22/newbornguidance072220. *See also FAQs: Management of Infants Born to Mothers with Suspected or Confirmed COVID-19*, AM. ACAD. OF PEDIATRICS (last updated Feb. 11, 2021), https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/faqs-management-of-infants-born-to-covid-19-mothers/ (noting, in guidance updated in February 2021, that if a mother is "acutely ill with COVID-19," then it may be recommended that the newborn be separated temporarily from the mother).

97. Alison Stuebe, *Should Infants Be Separated from Mothers with COVID-19? First, Do No Harm*, 15 BREASTFEEDING MED. 351, 351 (2020).

98. WORLD HEALTH ORG., CLINICAL MANAGEMENT OF SEVERE ACUTE RESPIRATORY INFECTION (SARI) WHEN COVID-19 DISEASE IS SUSPECTED 11–12 (2020). The UK's Royal College of Obstetricians & Gynaecologists similarly advised that birthing parents and newborns remain together, citing the benefits related to feeding and bonding. *Coronavirus Infection and Pregnancy*, ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/?fbclid=IwAR0Ncyovu935FEoZ11D8U46JioR3i5N_A0bR-bBb70rOxewybtccw5f3EyE (last visited Feb. 19, 2021).

99. *See, e.g.*, Troy Brown, *Mother-Baby Separation for COVID-19 Not Evidence-Based, Experts Say*, MEDSCAPE (Apr. 5, 2020), https://www.medscape.com/viewarticle/928158; Stuebe, *supra* note 97.

100. *See* Jennifer L. Neczypor & Sharon L. Holley, *Providing Evidence-Based Care During the Golden Hour*, 21 NURSING FOR WOMEN'S HEALTH 462, 471 (2017).

101. *Id*. *See also* Stuebe, *supra* note 97 (noting separated infants have higher heart rates and respiratory rates, as well as lower glucose levels, than newborns who maintain skin-to-skin contact with their parents). Similarly, studies have shown mothers who have skin-to-skin contact with their

Separation also interferes with the stimulation and production of breastmilk through early and frequent latching of the newborn, which delivers antibodies specific to maternal antigen exposure, mitigating the impact of viral infections and reducing the risk of subsequent hospitalization for pneumonia.[102] Delayed latching, even if the parent expresses milk to feed with a bottle, may interfere with the ability to breastfeed later.[103] Finally, newborn separation precludes skin-to-skin contact and early bonding, which is associated with better postpartum maternal mental health and may have positive benefits for the parent-child relationship in later years.[104] In addition to the adverse health impacts, newborn separation requires space, staff, and equipment that were already in short supply in many hospitals.[105] Further, segregating an infant away from the parent did not eliminate the infant's risk of contracting COVID-19 from exposed medical staff providing care in place of the parent.[106] Critics of the AAP/CDC position argued that the elimination of an unknown (and possibly non-existent) risk of parent-infant transmission immediately postpartum was not worth these tradeoffs.[107]

It was not until July 2020 that the AAP updated its guidance and recommended rooming-in of mothers with suspected or confirmed COVID-19 and their newborns, along with appropriate precautions to protect infants from infection.[108] In that update, the AAP noted that months of experience with babies of mothers who tested positive for COVID-19 suggested there was no difference in the likelihood of infection for infants who were separated and those who remained with their mothers using appropriate precautions.[109] The CDC similarly updated its guidance on August 3, 2020, emphasizing the significance

newborns have decreased heart rates, salivary cortisol levels, and stress scores—which are significant in light of the potential for maternal stress to worsen the impact of COVID-19. *Id.*

102. Stuebe, *supra* note 97, at 351–52. *See also* WORLD HEALTH ORG., *supra* note 98, at 11 (detailing protective effects of breastfeeding).

103. *See* Kristin E. Svensson et al., *Effects of Mother-Infant Skin-to-Skin Contact on Severe Latch-On Problems in Older Infants: A Randomized Trial*, INT'L BREASTFEEDING J., Mar. 2013, at 1, 2 (noting that "delayed first suckling" can negatively impact breastfeeding).

104. *See, e.g.*, Ann Bigelow, et al., *Effect of Mother/Infant Skin-to-Skin Contact on Postpartum Depressive Symptoms and Maternal Physiological Stress*, 41 J. OBSTETRIC, GYNECOLOGIC, & NEONATAL NURSING 369, 376 (2012) (finding early skin-to-skin contact reduces mothers' depressive symptoms and postpartum psychological stress); Ann E. Bigelow & Michelle Power, *Mother-Infant Skin-to-Skin Contact: Short- and Long-Term Effects for Mothers and Their Children Born Full-Term*, FRONTIERS PSYCH., Aug. 2020, at 1, 7 (finding skin-to-skin contact in infancy is associated with benefits to mother-child relationship nine years later).

105. Stuebe, *supra* note 97, at 352.

106. *See id.*

107. *See id.* at 351.

108. Wyckoff, *supra* note 96.

109. *Id*.

of autonomy in maternity care decision-making.[110] Throughout this time, birthing people retained the right to refuse separation, but not all hospitals informed patients of this right or provided advance counseling about the risks and benefits (including the WHO's position) in order to enable an informed choice after delivery.[111] This lack of information left patients with a positive or suspected COVID-19 result ill-equipped to advocate for themselves if they wished to remain with their babies. Disagreement about newborn separation left room for discretion in the application of these policies, which allowed for provider bias to influence decision-making. In fact, at least one hospital has been discovered to have engaged in racial profiling of Native American women under a secret policy, conducting COVID-19 screenings based on whether patients appeared to be Native American—even in the absence of symptoms or other risk factors—and routinely separating them from their newborns.[112]

Considering the conditions early in the pandemic, especially in COVID-19 hotspots, it is understandable that hospitals felt they needed to take extreme measures to protect their medical staff and patients. The policies discussed above were implemented during a time when fear was high, knowledge about COVID-19 was limited, and personal protective equipment (PPE) and testing equipment were in short supply.[113] But the policy changes implemented to limit COVID-19 exposure were not superficial; companion bans and newborn separations have significant impacts on the health and well-being of birthing people, infants, and their families.[114] Because people of color already have worse maternal and infant

110. *Care for Newborns*, CTRS. FOR DISEASE CONTROL & PREVENTION (last updated Dec. 8, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-newborns.html.

111. *See, e.g.*, Carmon, *supra* note 94.

112. *See* Bryant Furlow, *A Hospital's Secret Coronavirus Policy Separated Native American Mothers from Their Newborns*, PROPUBLICA (June 13, 2020), https://www.propublica.org/article/a-hospitals-secret-coronavirus-policy-separated-native-american-mothers-from-their-newborns (noting that staff instructions about the policy were silent about informed consent to infant removals and that in practice, patients were not given an opportunity to decline separation); Bryant Furlow, *Federal Investigation Finds Hospital Violated Patients' Rights by Profiling, Separating Native Mothers and Newborns*, PROPUBLICA (Aug. 22, 2020), https://www.propublica.org/article/federal-investigation-finds-hospital-violated-patients-rights-by-profiling-separating-native-mothers-and-newborns#:%7E:t%E2%80%A6 (reporting federal investigation found hospital violated patients' rights).

113. King & Shah, *supra* note 91. *See generally* Hannah Gold & Claire Lampen, *New York Hospitals Will Not Ban Partners During Child Birth*, THE CUT, (Mar. 29, 2020), https://www.thecut.com/2020/03/new-york-hospitals-will-not-ban-visitors-during-childbirth.html (quoting Columbia University Medical Center chief of obstetrics, noting concerns about exposed medical staff, discussing visitor exclusion: a "very difficult decision and not one taken lightly").

114. *See, e.g.*, *Maternal Separation Stresses the Baby, Research Finds*, SCIENCEDAILY (Nov. 2, 2011), https://www.sciencedaily.com/releases/2011/11/111102124955.htm.

health outcomes than White people,[115] and because they are disproportionately likely to contract and suffer harm from COVID-19,[116] they were exposed to a greater risk of adverse maternal and infant health consequences as a result of COVID-19 risk-reduction policies. Faced with the burden of shifting obstetric policies, it is not surprising that many pregnant people looked elsewhere for birthing options that would enable them to avoid the hospital entirely.[117]

IV. ANOTHER OPTION: BENEFITS OF CHOOSING MIDWIFERY

Giving birth outside the hospital is a reasonable choice for pregnant people experiencing low-risk pregnancies. Options include delivering at a freestanding birth center with midwives or birthing at home with a skilled attendant, who is usually a midwife (though a small number of physicians attend home births).[118] Together these out-of-hospital birth options are often referred to as community birth.[119] There are a variety of reasons why community birth is an appealing choice for a growing number of pregnant people, including the individualized care midwives provide, fewer interventions, the desire to avoid hospital settings, or distrust of medical providers due to previous mistreatment.[120] This Part will describe the midwifery model of care and summarize existing research on the safety and health benefits of midwifery before briefly considering why racism

115. GOPAL K. SINGH, HEALTH RES. & SERVS. ADMIN., MATERNAL MORTALITY IN THE UNITED STATES, 1935-2007: SUBSTANTIAL RACIAL/ETHNIC, SOCIOECONOMIC, AND GEOGRAPHIC DISPARITIES PERSIST (2010).

116. *Health Equity Considerations and Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION (last updated July 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html.

117. *See* Frank, *supra* note 9 (interviewing women who cited companion bans as inspiration for pursuing home birth). *See also* MIDWIVES' ASS'N OF WASH. STATE, INTERIM GUIDELINES FOR COMMUNITY-BASED MIDWIVES DURING THE COVID-19 PANDEMIC 2, 12, https://www.washingtonmidwives.org/uploads/1/1/3/8/113879963/maws_and_wamcrc_interim_guidelines_for_community-based_midwives_during_covid-19_pandemic_3.31.2020.pdf (last updated Mar. 31, 2020) (providing example of guidelines for midwifery practice during the pandemic, which discuss inclusion of support people and adopt the WHO's position that breastfeeding/chestfeeding by a COVID-19-positive parent is safe and should be encouraged with proper precautions).

118. In addition, some pregnant people may choose to give birth at home unassisted, which is considered less safe than birthing with a trained midwife or physician. *See* Ashley Marcin, *Unassisted Birth: Definition, Reasons, Risks, and More*, HEALTHLINE (Oct. 14, 2020), https://www.healthline.com/health/pregnancy/unassisted-birth. *But see, e.g.*, Imani Bashir, *Pregnant Black Women Are Dying at Terrifying Rates—That's Why I Chose an Unassisted Home Birth*, GLAMOUR (Mar. 1, 2019), https://www.glamour.com/story/i-chose-an-unassisted-home-birth.

119. *See* Cheyney et al., *supra* note 2.

120. Although community birth represents less than 2% of all births annually, the number of people choosing to deliver outside the hospital increased 85% from 2004 to 2017, when it was 1.61%. Marian F. MacDorman & Eugene Declercq, *Trends and State Variations in Out-of-Hospital Births in the United States, 2004-2017*, 46 BIRTH 279, 286 (2019).

and other forms of bias in medicine may lead Black women and other people of color to seek community birth—whether before the pandemic or during the time of COVID-19.

The Midwives Model of Care is distinct from the practice of medicine, focusing on "monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle[;] providing the mother/birthing parent with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery and postpartum support[;] minimizing technological interventions[;] and identifying and referring women/birthing people who require obstetrical attention."[121] Midwifery care is appropriate for people experiencing low-risk pregnancies; midwives are trained to identify and refer pregnant people with health conditions or complications that necessitate more specialized care elsewhere.[122]

Before and after the birth, midwifery clients typically have longer appointments than patients in obstetric practices.[123] They have opportunities to discuss their psychosocial needs, receive counseling about nutrition and healthy habits, have multiple postpartum appointments (sooner than in obstetrics and often including home visits), and receive lactation support.[124] Generally, intrapartum care by midwives reflects a non-interventionist mindset, which considers childbirth to be a natural, physiologic process.[125] A non-interventionist approach includes waiting for spontaneous labor to begin, intermittent monitoring of fetal heart tones (rather than continuous electronic fetal monitoring, which confines the birthing person to the bed), reliance on natural pain relief methods, use of mobility and squatting positions to facilitate

121. *About Us: The Midwives Model of Care*, MIDWIVES ALL. N. AM., http://mana.org/about-midwives/midwifery-model [hereinafter *Midwives Model*]. There is disagreement within the midwifery community about whether to use "women" or the more inclusive "pregnant people" to refer to clients. *See id.*

122. *See* Saraswathi Vedam, et al., *Transfer from Planned Home Birth to Hospital: Improving Interprofessional Collaboration*, 59 J. MIDWIFERY & WOMEN'S HEALTH 624, 625, 628 (2014).

123. *Choosing and OB-GYN or Midwife*, WOMEN'S HEALTH OF W. N.Y. (last visited June 24, 2021), http://womenshealthofwny.com/choosing-an-ob-gyn-or-midwife/ (noting that "[a]ppointments with a CNM are generally longer than those with an OB-GYN").

124. *E.g.*, Riddle Hospital, *Having a Midwife and an OB/GYN, Best of Both Worlds*, MAIN LINE HEALTH: WELL AHEAD BLOG (Mar. 25, 2019), https://www.mainlinehealth.org/blog/2019/03/25/having-a-midwife-and-an-obgyn.

125. *Models of Maternity Care*, OUR BODIES OURSELVES (Apr. 2, 2014), https://www.ourbodiesourselves.org/book-excerpts/health-article/models-of-maternity-care/ (comparing midwifery's physiologic model, which refers to "care in accord with the normal functioning of a woman's body," with the "interventionist or pathology-driven model" associated with the medical model of care).

contractions, and waiting for the urge to push (rather than being directed to push by a third party).[126]

While all midwives generally share a non-interventionist philosophy, there are several different types of midwives, distinguished by credential and licensing status. Midwives may hold one (or more) of three different types of credentials: the Certified Professional Midwife (CPM), the Certified Nurse Midwife (CNM), and the Certified Midwife (CM).[127] Certified Nurse Midwives receive training as registered nurses before pursuing specialized midwifery training.[128] They are trained to attend births in hospitals, birth centers, and at home, though they predominantly practice in hospitals.[129] By contrast, CPMs and CMs enter the midwifery profession directly without nursing training.[130] CMs primarily attend births in hospitals but may also work in birth centers and at home; CPMs attend births in birth centers and at home.[131] Their direct path to practice means they may be referred to as "direct-entry midwives."[132] Apart from their credentials, midwives may hold a state license from the relevant state agency.[133] Finally, some midwives choose not to obtain a national credential or license, often for philosophical objections or practical barriers.[134] Such midwives may be called traditional midwives or lay midwives.[135]

Research shows midwifery care is not only a safe option for people experiencing low-risk pregnancy, but with its non-interventionist approach, midwifery is associated with fewer health complications, including fewer

126. *See* Kukura, *supra* note 13, at 271–75 (contrasting the midwifery model of care with the medical model of childbirth). *See generally* HENCI GOER & AMY ROMANO, OPTIMAL CARE IN CHILDBIRTH: THE CASE FOR A PHYSIOLOGIC APPROACH (2012) (analyzing the evidence supporting a physiologic approach to childbirth and detailing practices from the onset of labor through delivery that align with a non-interventionist care philosophy).

127. *Comparison of Certified Nurse-Midwives, Certified Midwives, Certified Professional Midwives Clarifying the Distinctions Among Professional Midwifery Credentials in the U.S.*, AM. COLL. OF NURSE-MIDWIVES (Oct. 2017), https://www.midwife.org/acnm/files/ccLibraryFiles/FILENAME/000000006807/FINAL-ComparisonChart-Oct2017.pdf [hereinafter *Midwife Comparison Chart*].

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. *Direct-Entry Midwifery*, NAT'L MIDWIFERY INST., https://www.nationalmidwiferyinstitute.com/direct-entry-midwifery (2018) (last visited Feb. 23, 2021).

133. *See, e.g.*, *Midwifery - Questions & Answers*, OFF. OF THE PROS., http://www.op.nysed.gov/prof/midwife/midwifeqa.htm (last visited Mar. 24, 2021).

134. *See* Kukura, *supra* note 13, at n.187 (discussing objections to credentialing or licensure within the midwifery community).

135. *Types of Midwives*, MIDWIVES ALL. N. AM., https://mana.org/about-midwives/types-of-midwife (last visited Mar. 24, 2021); Robbie E. Davis-Floyd, *The Ups, Downs, and Interlinkages of Nurse- and Direct-Entry Midwifery: Status, Practice, and Education*, DAVIS-FLOYD.COM 3 (1998), http://www.davis-floyd.com/wp-content/uploads/2016/11/MTeduc14.pdf.

instrumental or surgical deliveries.[136] Extensive research on midwife-led care generally has identified no adverse outcomes associated with midwifery and such research has reported better outcomes on a variety of maternal health measures, including: a reduced likelihood of pregnancy-induced hypertension and preeclampsia; a reduction in the number of procedures during labor; less need for pain medication during labor; lower incidence of pre-term birth and miscarriage before twenty-four weeks of pregnancy; fewer inductions and episiotomies; less perineal tearing during delivery; decreased likelihood of needing a cesarean; and increased satisfaction for women receiving midwife-led care.[137]

The health and safety record of midwifery-led care includes birth center deliveries and home births, confirming that home birth is a reasonable choice for people experiencing low-risk pregnancies. The Midwives Alliance of North America study, which is the largest existing analysis of planned home births in the United States, confirms the safety of home birth.[138] Researchers found a cesarean rate of 5.2% (after transfer to the hospital), lower rates of medical interventions than hospital births, and just 0.9% of babies requiring transfer to the hospital after delivery, mostly for non-urgent conditions.[139] In addition, the data revealed significant health benefits resulting from midwife-led care, as ninety-two percent of babies were born full term and nearly ninety-eight percent of infants were breastfed at six weeks postpartum.[140] Two 2015 studies found lower risk of complications for women who delivered at home, although the studies reached slightly different conclusions about the risks to babies.[141] A 2009 study found that women who delivered at home with midwives had half as many

136. *See, e.g.*, Katy Sutcliffe, et al., *Comparing Midwife-Led and Doctor-Led Maternity Care: A Systematic Review of Reviews*, 68 J. ADVANCED NURSING 2376, 2381–83 (2012).

137. *See, e.g.*, *id.*; Jane Sandall, et al., *Midwife-Led Continuity Models Versus Other Models of Care for Childbearing Women*, COCHRANE DATABASE OF SYS. REVS., no. 4, 2016, at 2.; Robin P. Newhouse, et al., *Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review*, 29 NURSING ECON. 230, 243 tbl.5b, 245 (2011); Dina Khan-Neelofur, et al., *Who Should Provide Routine Antenatal Care for Low-Risk Women, and How Often? A Systematic Review of Randomised Controlled Trials*, 12 PAEDIATRIC & PERINATAL EPIDEMIOLOGY 7, 19 (1998). See Kukura, *supra* note 13, at 275–78, for additional discussion of the health benefits associated with midwifery care.

138. *See* Melissa Cheyney, et al., *Outcomes of Care for 16,924 Planned Home Births in the United States: The Midwives Alliance of North America Statistics Project, 2004 to 2009*, 59 J. MIDWIFERY & WOMEN'S HEALTH 17, 26 (2014).

139. *Id.* at 20, 22–24.

140. *Id.* at 21, 23.

141. *Compare* Jonathan M. Snowden, et al., *Planned Out-of-Hospital Birth and Birth Outcomes*, 373 NEW ENG. J. MED. 2642, 2645, 2652 (2015) (finding 1.24 more perinatal deaths per 1,000 deliveries among women who had planned home births as compared with women who had planned hospital births), *with* Eileen K. Hutton, et al., *Outcomes Associated with Planned Place of Birth Among Women with Low-Risk Pregnancies*, 188 CAN. MED. ASS'N J. E80, E86, E88 (2015) (finding no significant difference in infant mortality between out-of-hospital births and in-hospital births).

serious perineal tears and approximately a third less postpartum bleeding than women who delivered in the hospital.[142] Considered together, the research on midwifery's health and safety record suggests: (1) giving birth with a midwife is a safe and reasonable option for people experiencing low-risk pregnancies, whether in a hospital or community setting, and (2) even when comparing only the results for similarly situated patients, people birthing with midwives report less need for medical intervention during childbirth than physician-attended patients, a lower cesarean rate, and better health outcomes on various measures.

For Black women and other pregnant people of color, community birth with midwives also offers an opportunity to avoid the racism and discrimination that is all too common in medical settings.[143] It is clear that racism is present in medical education and clinical settings, both of which are institutions shaped by the structural racism that exists throughout American society.[144] The belief that race is rooted in biology—rather than a social construct—persists among some health care providers, leading to alarming care differentials between White and Black patients within medical settings. For example, some medical professionals do not believe Black patients when they describe symptoms or discount their complaints about pain, leading to inferior medical care.[145] In a 2016 study, half of White medical trainees believed at least one myth about the physiological differences between Black and White people, including that Black people feel less pain than White people due to less sensitive nerve endings,[146] which can lead to inadequate pain management for Black patients.[147] In addition, one-third

142. Patricia A. Janssen, et al., *Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician*, 181 CAN. MED. ASS'N. J. 377, 379 (2009).

143. *See e.g.*, Dána-Ain Davis, *Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing*, 38 MED. ANTHROPOLOGY 560, 568, 570 (2018); Paige Nong et al., *Patient-Reported Experiences of Discrimination in the US Health Care System*, JAMA NETWORK, Dec. 15, 2020, at 4 (reporting twenty-one percent of adults experienced discrimination in the health care system, with racial/ethnic discrimination the most frequently reported type of discrimination); Aya Nuriddin et al., *Reckoning with Histories of Medical Racism and Violence in the USA*, 396 LANCET 949, 949 (Oct. 30, 2020); Altaf Saadi, *Opinion: American-Muslim Doctor Reflects on Bigotry at Some Top Hospitals, and Beyond*, WBUR COMMONHEALTH (Jan. 8, 2016), https://www.wbur.org/commonhealth/2016/01/08/hospital-bigotry-opinion.

144. Rachel L. Hardeman et al., *Structural Racism and Supporting Black Lives—The Role of Health Professionals*, 375 NEW ENG. J. MED 2113, 2113 (2016); Max J. Romano, *White Privilege in a White Coat: How Racism Shaped My Medical Education*, 16 ANNALS FAM. MED. 261, 262 (2018).

145. *See* Joseph V. Sakran et al., *Racism in Health Care Isn't Always Obvious*, SCI. AM. (July 9, 2020), https://www.scientificamerican.com/article/racism-in-health-care-isnt-always-obvious/.

146. *See* Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4298 (2016).

147. *See* Ronald Wyatt, *Pain and Ethnicity*, 15 AM. MED. ASS'N J. ETHICS VIRTUAL MENTOR 449, 449 (2013).

of these doctors believed falsely that Black skin is thicker than White skin.[148] Significantly, research suggests that implicit bias on the part of physicians perpetuates racial health care disparities,[149] and by extension, the social and economic inequity that stems from higher rates of chronic disease, disability, uninsurance, and medical debt.[150]

At the individual level, racial bias by physicians is associated with poor patient-provider communication and negative patient experiences.[151] Physician bias affects the quality of care Black people receive, provider perceptions of Black patients' complaints, and the amount of time providers spend with Black patients.[152] Racism in health care has particularly acute consequences for maternal and infant health outcomes, where the race disparities are stark.[153] For example, racism in medicine delays Black women from seeking prenatal care.[154] Lack of attention to or skepticism of Black women reporting symptoms lead to deaths from preventable prenatal or postpartum complications,[155] as well as many near-misses.[156]

Midwifery is not a panacea for racism in medicine—nor is midwifery itself free from racism and bias, whether on an individual or profession-wide level.[157] But the midwifery model—which values individual relationships and support throughout the childbearing cycle, holistic counseling and attention to psycho-social factors that contribute to (or limit) prenatal and postpartum well-being,

148. *See* Hoffman et al., *supra* note 146, at 4298.

149. *See* Elizabeth N. Chapman et al., *Physicians and Implicit Bias: How Doctors May Unwittingly Perpetuate Health Care Disparities*, 28 J. GEN. INTERNAL MED. 1504, 1504 (2013); John F. Dovidio et al., *Under the Radar: How Unexamined Biases in Decision-Making Processes in Clinical Interactions Contribute to Health Care Disparities*, 102 AM. J. PUB. HEALTH 945, 945 (2012).

150. *See Social Determinants of Health: Achieving Health Equity by Addressing the Social Determinants of Health*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/chronicdisease/programs-impact/sdoh.htm (last updated Oct. 29, 2020).

151. *See* Lisa A. Cooper et al., *The Associations of Clinicians' Implicit Attitudes About Race with Medical Visit Communication and Patient Ratings of Interpersonal Care*, 5 AM. J. PUB. HEALTH 979, 983 (2012).

152. *See* Abrams, *supra* note 50 (citing research).

153. *See supra* Part II; Samantha Artiga et al., *Racial Disparities in Maternal and Infant Health: An Overview*, KAISER FAM. FOUND. (Nov. 10, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-maternal-infant-health-overview/.

154. *See* Jaime C. Slaughter-Acey et al., *Skin Tone Matters: Racial Microaggressions and Delayed Prenatal Care*, 57 AM. J. PREVENTIVE MED. 321, 325–26 (2019).

155. *See* Nina Martin et al., *Lost Mothers*, PROPUBLICA (July 17, 2017), https://www.propublica.org/article/lost-mothers-maternal-health-died-childbirth-pregnancy.

156. *See, e.g.*, Rob Haskell, *Serena Williams on Motherhood, Marriage, and Making Her Comeback*, VOGUE (Jan. 10, 2018) (discussing repeated provider disbelief of her postpartum symptoms of a pulmonary embolism).

157. *See, e.g.*, Jyesha Wren Serbin & Elizabeth Donnelly, *The Impact of Racism and Midwifery's Lack of Racial Diversity*, 61 J. MIDWIFERY & WOMEN'S HEALTH 694, 703 (2016); Kukura, *supra* note 13, at 256–59 (discussing racism in the development of modern midwifery).

and patient-centered care with meaningful informed consent and respect for autonomy—offers an important alternative for birthing people whose needs are not met during hospital-based care due to racism and bias.[158] This is particularly true for pregnant people who have experienced mistreatment by maternity care providers previously—who are disproportionately women of color[159]—and for survivors of sexual assault and other forms of violence, who may be retraumatized being observed and touched by strangers during a hospital delivery.[160] In addition, community-based midwifery practices generally have smaller caseloads relative to hospital obstetrics departments, reducing the number of people midwives come in contact with and limiting potential COVID-19 exposure for other pregnant clients.[161] Ultimately, midwifery offers a variety of benefits, especially for people of color who experience racism and bias in medical settings, that made midwifery-attended community birth an attractive option for many pregnant people during the COVID-19 pandemic.

V. FEELING STUCK: LEGAL BARRIERS TO MOVING BIRTH OUT OF THE HOSPITAL

As pregnant people looking to avoid the hospital during the pandemic discovered all too quickly, access to community birth is restricted in many places across the United States and is sometimes completely unavailable.[162] As a result of the historical suppression of midwives[163] and modern-day regulatory

158. *See Midwives Model*, *supra* note 121; Davis, *supra* note 143 (arguing that midwives play a role in mediating obstetric racism); *See* also Julia Chinyere Oparah et al., BATTLING OVER BIRTH: BLACK WOMEN AND THE MATERNAL HEALTH CARE CRISIS 14 (2018) (reporting that in study of one hundred Black women who had given birth in California, "[n]one of our participants who worked with a midwife/doula team reported feeling disempowered or very disempowered, compared to 31 percent of those who were attended by a physician/nurse team"); Frank, *supra* note 9 (quoting a woman who transferred to home birth midwifery care: "We shouldn't have to fight to be heard and listened to and respected over our body, which happens so often in a hospital.").

159. Vedam et al., *supra* note 12, at 8.

160. *See* Sara Beaulieu, *Commentary: When Sexual Violence Survivors Give Birth, Here's What You Should Know*, WBUR (Jan. 21, 2016), https://www.wbur.org/commonhealth/2016/01/21/sexual-violence-survivor-childbirth.

161. *Compare Medscape OB/GYN Compensation Report: 2011 Results*, MEDSCAPE, https://www.medscape.com/features/slideshow/compensation/2011/womenshealth (last visited Feb. 18, 2021) (showing in 2011 the average obstetrician saw fifty to ninety-nine patients per week) *with FAQs/Practice Statistics*, CMTY. MIDWIFERY CARE, http://www.communitymidwifery.com/faqs/ (last visited Feb. 18, 2021) (showing a solo midwife practice limiting their patient load to two or three patients due per month).

162. *See* Saraswathi Vedam, et al., *Mapping Integration of Midwives Across the United States: Impact on Access, Equity, and Outcomes*, PLOS ONE, Feb. 21, 2018, at 1, 2 [hereinafter *Mapping Integration*].

163. *See* Kukura, *supra* note 13, at 281–283 (discussing historical marginalization of midwives, including racist propaganda campaigns by physicians that characterized midwives—many of whom

restrictions on the practice of midwifery,[164] some pregnant people have no opportunity to deliver outside the hospital setting with a trained attendant. This Part describes how overly restrictive regulation of midwives in many jurisdictions has suppressed growth of the profession and created community birth deserts that limit the choices of birthing people. Even in non-pandemic times, these restrictions inhibit consumer choice, deprive pregnant people who seek midwifery care of the health-promoting benefits of midwifery, and contribute to health disparities by putting midwifery care out of reach for people who lack insurance coverage for out-of-hospital birth and cannot otherwise afford it.[165] During the pandemic, as more pregnant people sought community birth options in order to minimize risk of COVID-19 exposure,[166] legal restrictions on midwifery made gaps in access to this care even more problematic.

As discussed previously, midwives in the United States may be certified nurse-midwives (CNMs), certified professional midwives (CPMs), or certified midwives (CMs).[167] Certified Nurse Midwives are licensed in all fifty states, have nursing training, are covered by insurance, and practice predominantly in hospitals, though they may also receive training in out-of-hospital birth.[168] As of February 2019, there were 12,218 CNMs practicing in the United States.[169] CPMs are direct-entry midwives (DEMs)—meaning they do not start with nursing education—who are trained to attend births in birth centers or at home.[170] As of October 2020, there were 2500 CPMs with active certification in

were either immigrants or descendants of trafficked slaves—as "filthy and ignorant and not far removed from the jungles of Africa"). The regulatory landscape discussed in this Part is analyzed more fully in *Better Birth*.

164. *See* Kukura, *supra* note 13, at 286–88 (discussing the modern marginalization of midwives through regulatory hostility).

165. *Id.*

166. *See* Julia Ries, *Interest in Home Births Rises During the COVID-19 Pandemic*, HEALTHLINE (June 17, 2020), https://www.healthline.com/health/pregnancy/home-births-rise-with-covid-19.

167. *Midwife Comparison Chart*, *supra* note 127. Midwives who practice without a credential are often called traditional or lay midwives. It is uncertain how many traditional midwives currently practice in the U.S. Because they generally fall outside the purview of the state licensing laws, this Section will not focus on the legal status of traditional midwives—though they continue to be vulnerable to legal sanction for engaging in the unauthorized practice of medicine or nursing, or for violating related provisions. *See* Ellen M. Baumann et al., *Chapter 1: Why You Aren't Safe!*, FROM CALLING TO COURTROOM (2004), http://www.fromcallingtocourtroom.net/default.htm.

168. *The Credential CNM and CM*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/The-Credential-CNM-and-CM (last visited June 5, 2021) [hereinafter *Credential CNM and CM*]; *Midwife Comparison Chart*, *supra* note 127.

169. *Essential Facts About Midwives*, AM. COLL. OF NURSE-MIDWIVES, https://www.midwife.org/acnm/files/cclibraryfiles/filename/000000007531/EssentialFactsAboutMidwives-UPDATED.pdf (last updated May 2019) [hereinafter *Essential Facts*].

170. *Midwife Comparison Chart*, *supra* note 127.

the United States.[171] CMs are direct-entry midwives who have a background in a health-related field other than nursing and are trained to attend birth in hospitals, freestanding birth centers, or at home.[172] As of February 2019, there were 102 CMs in the United States, and they were eligible for licensure in only six states.[173]

There are three general categories of restrictions that contribute to the undersupply of community birth options across the United States: (1) lack of licensure for CPMs in fourteen states and for CMs in forty-four states;[174] (2) restricted autonomy and limited scope of practice for CNMs, CPMs, and CMs in various jurisdictions;[175] and (3) regulatory hurdles to establishing more freestanding birth centers, including the lack of state licensure for birth centers and various burdensome regulatory requirements.[176]

First, the lack of licensure for CPMs in fourteen states discourages midwives from training and practicing in those states, suppressing the supply of midwives available to attend birth in community settings.[177] While some CPMs do nevertheless choose to practice in unlicensed states, they are vulnerable, knowing they could be subject to legal action in the event of a bad outcome.[178] Where CPMs have successfully obtained state licensure, it often required long, contentious political campaigns that brought midwives into conflict with local and national medical associations,[179] with physician opposition resulting from concern about economic competition or other anti-midwife bias.[180] Without full licensure, there will continue to be an undersupply of CPMs to meet the demand

171. Email from Ida Darragh, Exec. Dir., N. Am. Registry of Midwives, to author (Oct. 23, 2020, 8:30 PM) (on file with author).

172. *Midwife Comparison Chart*, *supra* note 127.

173. *Essential Facts*, *supra* note 169.

174. *See CPMs Legal Status by State*, THE BIG PUSH FOR MIDWIVES, https://www.pushformidwives.org/cpms_legal_status_by_state (last visited Feb. 18, 2021); *Credential CNM and CM*, *supra* note 168.

175. *See, e.g.*, *How Does the Role of Nurse-Midwives Change from State to State?*, GEO. UNIV. SCH. OF NURSING & HEALTH STUD. (Feb. 5, 2019), https://online.nursing.georgetown.edu/blog/scope-of-practice-for-midwives/.

176. Lesley Rathbun, Am. Ass'n of Birth Cent., Comment Letter on Federal Register Notice Examining Health Care Competition 2 (Apr. 30, 2014), https://www.ftc.gov/system/files/documents/public_comments/2014/04/00171-90023.pdf.

177. *CPMs Legal Status by State*, *supra* note 174. This discussion focuses on CPMs because they are more numerous and widely recognized than CMs, but elsewhere the Article uses "DEMs" to refer to all direct-entry midwives—CPMs and CMs—collectively.

178. *See, e.g.*, Jennifer Block, *The Criminalization of the American Midwife*, LONG READS (Mar. 10, 2020), https://longreads.com/2020/03/10/criminalization-of-the-american-midwife/.

179. *See* Katherine Beckett & Bruce Hoffman, *Challenging Medicine: Law, Resistance, and the Cultural Politics of Childbirth*, 39 LAW & SOC'Y REV. 125, 137, 154 (2005) (quoting a representative of the Illinois Medical Association who criticized the education and training of midwives during a legislative hearing).

180. *See* Kukura, *supra* note 13, at 281–88.

of pregnant people who want to give birth at home, especially when COVID-19—or the next public health crisis—makes people feel less safe delivering in hospitals.[181]

Second, both DEMs and CNMs face restrictions on their autonomy and limitations on their scope of practice, depending on where they work and the degree of acceptance and cooperation that exists with area physicians. Some states require one or more types of midwives to enter into a collaborative agreement with a supervising physician in order to practice lawfully, or to consult with a physician in order to treat patients with certain conditions.[182] They may also face limitations on prescriptive authority, including the requirement that they enter into a separate agreement with a physician in order to prescribe certain drugs, which precludes some midwives from accessing necessary medications.[183] There is no evidence that collaborative agreements, mandatory consultations, or limits on prescriptive authority serve a valid public goal where midwives are already licensed, having satisfied the state's requirements for education and training. In fact, research shows that greater access to and integration of midwives into mainstream maternity care is associated with better health outcomes on a variety of measures, where integration reflects fewer non-evidence-based restrictions on how midwives practice.[184] Such requirements can, however, present an insurmountable hurdle for midwives who live and work in areas where local physicians are hostile to midwives and refuse to sign a collaborative agreement.[185] Even where physicians recognize that midwives serve a valuable role in maternity care and are willing to sign collaborative agreements, the fact that the state has imposed a relationship on two licensed

181. Because Medicaid providers must be licensed, lack of licensure also presents a barrier to eventual inclusion of CPMs within the federal Medicaid program and thus to home birth coverage for the low-income pregnant people who rely on Medicaid. *CPMs: Midwifery Landscape and Future Directions*, NAT'L ASS'N OF CERTIFIED PRO. MIDWIVES 2 (2017), http://www.nacpm.org/wp-content/uploads/2017/10/2A-NACPM-Vision-and-National-Landscape-for-CPMs.pdf. Although sixteen states currently include CPMs in Medicaid through a state plan amendment, *see Direct Entry Midwifery State-by-State Legal Status*, N. AM. REGISTRY OF MIDWIVES (Apr. 18, 2021), https://narm.org/pdffiles/Statechart.pdf (noting total as of April 2021), midwifery advocates are engaged in legislative advocacy to secure Medicaid coverage at the federal level for all licensed CPMs. NAT'L ASS'N OF CERTIFIED PRO. MIDWIVES, *supra*.

182. *See Mapping Integration*, *supra* note 162 at 6–8 (detailing midwifery practice and interprofessional collaboration in all fifty states); AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, TASK FORCE ON COLLABORATIVE PRAC., COLLABORATION IN PRACTICE: IMPLEMENTING TEAM-BASED CARE 18 (2016).

183. *Id.* at 18, 19.

184. *See Mapping Integration*, *supra* note 162, at 11–12.

185. *See, e.g.*, Deborah Walker et al., *Midwifery Practice and Education: Current Challenges and Opportunities*, ONLINE J. ISSUES NURSING, May 31, 2014, https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No2-May-2014/Midwifery-Practice-and-Education.html (discussing the difficulty some midwives have securing a collaborative agreement and related economic implications of this requirement).

professionals may impede the development of truly collaborative interprofessional relationships built on trust, mutual respect, and a shared desire to provide the best care for childbearing people.[186]

In addition, DEMs may face explicit prohibitions on caring for pregnant people carrying twins, people whose babies are breech, or people who want to deliver vaginally after a prior cesarean.[187] Such restrictions deprive pregnant people needing such care of the right to make an informed choice and may instead force them to choose between a hospital birth with an increased likelihood of medical intervention, including cesarean surgery, as well as the heightened risk of COVID-19 exposure, or an unassisted home birth without the benefit of a trained attendant.[188]

Third, although freestanding birth centers (FBCs) represent a comfortable middle ground between hospital and home birth for some pregnant people, lack of licensure in certain states, onerous certificate of need requirements, and other unnecessary regulations mean that many pregnant people do not have access to an FBC.[189] Often owned and operated by midwives, FBCs have a strong record of promoting healthy birth outcomes, including fewer births by cesarean surgery.[190] There are approximately 384 freestanding birth centers currently operating across the United States.[191] Forty-one states plus the District of Columbia offer some form of licensing for FBCs; of the remaining states, in all but one, birth centers remain unregulated and thus may operate without a license,

186. *See* Denise Colter Smith, *Midwife-Physician Collaboration: A Conceptual Framework for Interprofessional Collaborative Practice*, 60 J. MIDWIFERY & WOMEN'S HEALTH 128, 137 (2014) (concluding that "[a] working relationship that is entered into for the purposes of benefitting one group over the other is not collaboration, nor is a relationship that places one professional group subordinate to the other"); *Joint Statement of Practice Relations Between Obstetricians-Gynecologists and Certified Nurse-Midwives/Certified Midwives*, THE AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS, https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2018/joint-statement-of-practice-relations-between-ob-gyns-and-cnms (last updated Apr. 2018) (noting that "[q]uality of care is enhanced by collegial relationships characterized by mutual respect and trust").

187. *See, e.g.*, Rebecca Fotsch, *Regulating Certified Professional Midwives in State Legislatures*, 8 J. NURSING REGUL. 47, 48 (2017) (discussing Alabama bill that prohibited CPMs from attending multiple births and breech births).

188. *See, e.g.*, Kimberlie Kranich, *As US Home Births Increase, Options for Illinois Women Limited*, ILL. PUB. MEDIA (Jan. 11, 2013), https://will.illinois.edu/news/story/as-us-home-births-increase-options-for-illinois-women-limited.

189. Rathbun, *supra* note 176, at 9. Some hospitals have established birth centers with their facilities. *Id.* at 3. By contrast, freestanding birth centers offer care under the midwifery model. *Id.* at 6.

190. *See, e.g.*, URB. INST. ET AL., STRONG START FOR MOTHERS AND NEWBORNS EVALUATION IV (Oct. 2018).

191. *Highlights of 4 Decades of Developing the Birth Center Concept in the U.S.*, AM. ASS'N OF BIRTH CTRS., https://www.birthcenters.org/page/history (last visited Feb. 19, 2021).

but this precludes them from being eligible for most insurance coverage, including Medicaid.[192]

In addition, in states that require a Certificate of Need (CON)—a legal document required for the construction of new health care facilities, which involves an expensive and time-consuming process—pregnant people have less access to FBCs than in states without a CON law.[193] The process of securing a CON is particularly burdensome for birth centers, which are small businesses or non-profits that are often run by midwives, because it involves significant upfront financial costs and extensive regulatory hurdles.[194] In addition, hospitals have used the CON process to deter potential competition by derailing birth center proposals, despite the significant differences between what services each type of facility provides, thus injecting politics—and often anti-midwife bias—into a regulatory process that was designed to contain spiraling health care costs.[195] Furthermore, other regulatory hurdles limit access to community birth in birth centers. For example, states that require FBCs to maintain a written agreement with a transfer hospital, require a physician to serve as medical director, or require a written agreement with a physician in order to operate have fewer birth centers available to pregnant people within the state.[196] These regulations function to impede the establishment of new FBCs and thus limit the extent to which pregnant people can enjoy the health benefits of midwifery.

The extent to which midwives are marginalized within the maternity care arena is reflected in the failure of state governments to include midwives in emergency planning, including for modification of scope of practice rules, rules regarding essential workers and ability to travel, and provision of PPE.[197] Although overly burdensome, non-evidence-based regulation has long impeded

192. Rathbun, *supra* note 176.

193. *Position Statement: Birth Center Licensure and Regulations*, AM. ASS'N OF BIRTH CTRS. 2 (2017), https://cdn.ymaws.com/www.birthcenters.org/resource/resmgr/about_aabc_-_documents/AABC_PS_-_BC_Licensure_and_R.pdf [hereinafter *Position Statement*] (explaining why CON laws should not apply to FBCs).

194. *See* Lauren K. Hall, *Unnecessary Risk: Women Need Safer Options Than Giving Birth in Hospitals During Pandemic*, USA TODAY (Jan. 10, 2021, 6:01 AM), https://www.usatoday.com/story/opinion/2021/01/10/why-giving-birth-pandemic-riskier-than-should-column/6561318002/ (describing an outdated CON process that can cost aspiring birth centers hundreds of thousands of dollars and require up to two years to complete).

195. *Id.* (discussing hospital "veto power over birth center applications"). *See also Position Statement*, *supra* note 194; *CON—Certificate of Need State Laws*, NAT'L CONF. OF STATE LEGISLATURES (Dec. 1, 2019), https://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (acknowledging critique that "CON programs allow for political influence in deciding whether facilities will be built, which can invite manipulation and abuse").

196. *Position Statement*, *supra* note 193, at 2–3.

197. *See* BRBA REPORT, *supra* note 76, at 3 n.6 (noting that as of April 1, 2020, only two states—New York and New Jersey—had explicitly included midwives in their emergency executive orders).

access to midwifery,[198] the COVID-19 pandemic has brought into even sharper focus the devastating impact that lack of access to midwife-attended community birth has on pregnant people seeking to minimize exposure risk while giving birth during a global health crisis.

VI. RECOMMENDATIONS

The spread of COVID-19 has illuminated problems with how maternity care is organized in the United States, as it has with so much of the country's flawed and fragmented health care system. This Part will briefly identify several recommendations that emerge from the preceding analysis: (1) elimination of critical data gaps by reforming data collection on pregnancy and birth; (2) regulatory reform to enable licensure for all credentialed midwives, eliminate non-evidence-based regulation of midwives, encourage the creation of more freestanding birth centers, and provide flexibility for temporary expansion of community birth access in future health crises; and (3) promotion of interprofessional collaboration between midwives and physicians.

First, public health officials, researchers, and advocates should use the devastating gaps in data collection and knowledge production on COVID-19 and pregnancy to push reconsideration of how data on pregnancy and birth are collected in this country. Decentralized data collection and lack of strong federal oversight have left holes in critical information needed to inform evidence-based guidelines for maternal and infant care during COVID-19 and future health crises.[199] Officials should consider best practices outside the United States. For example, the U.K. Obstetric Surveillance System (UKOSS) is a research platform that was able to be mobilized quickly in the pandemic due to advance planning on the part of the public health authorities.[200] It collects comprehensive data but uses a straightforward two-page form to collect data in order to ease the burden on clinicians.[201] Although lack of universal health care and decentralization of vital statistics collection distinguish the United States from the United Kingdom, structural differences in the health care system that make data collection more complicated should not justify abdication of the government's responsibility to protect the health and safety of childbearing

198. *See e.g.*, Kukura, *supra* note 13, at 283–88 (discussing regulatory barriers that impede access to midwifery).

199. *See supra* Part II. Inadequate data collection on pregnancy and birth outcomes predates the pandemic and reflects a flawed (and underfunded) approach that has impeded efforts to tackle the country's maternal mortality crisis. *See* Robin Fields & Joe Sexton, *How Many American Women Die from Causes Related to Pregnancy or Childbirth? No One Knows.*, PROPUBLICA (Oct. 23, 2017, 8:00 AM), https://www.propublica.org/article/how-many-american-women-die-from-causes-related-to-pregnancy-or-childbirth.

200. *See* Martin, *supra* note 16 (quoting researcher: "I was told to activate [it] on a Friday . . . and by Monday we were collecting the data.").

201. *Id.*

people.[202] Policymakers should address the chronic underfunding of the U.S. emergency preparedness apparatus, including real-time data collection, in order to have an appropriate system in place for the next health crisis, so that the country does not have to rely on foreign nations to help public health officials understand the impact of disease on pregnant people and their infants.[203]

Second, states should embrace regulatory reform that will enable better integration of midwives into mainstream maternity care by providing a path to licensure for all credentialed midwives that is free of non-evidence-based restrictions. The inability of midwives to meet the demand for community birth among low-risk pregnant people during the pandemic[204] underscores the need for policymakers to prioritize midwifery promotion in the form of licensure for CPMs in the fourteen states where they are excluded (and for CMs in the vast majority of states where they are not recognized), as well as the elimination of unnecessary, physician-protectionist regulations that preclude midwives from practicing to the full extent of their training and certification. Such regulations do not serve public health goals but rather enable physicians to suppress access to midwifery care by refusing to cooperate with local midwives, often at the expense of pregnant people who want and would benefit from greater availability of community birth, including pregnant people of color whose experience of racism in medical settings interferes with their ability to receive good care and contributes to their higher rates of adverse health outcomes.[205]

202. *Id.* ("The U.K. treats every mother's death like a public health disaster; the U.S. can barely keep track of its maternal mortality problem.").

203. *Id.* (noting that by mid-May 2020, UKOSS had released an analysis of all hospitalized pregnant women who tested positive for COVID-19 to date, including key insights about the higher rates of hospitalization for Black, Asian, and Middle Eastern women who contracted the virus).

204. *See* Daviss et al., *supra* note 55, at 4 (noting a lack of data on the rate at which community birth increased during the pandemic but citing "ample suggestive evidence from across the country" about growing demand among American families for midwife-attended birth outside the hospital); Adelle Dora Monteblanco, *The COVID-19 Pandemic: A Focusing Event to Promote Community Midwifery Policies in the United States*, SOC. SCI. & HUMANITIES OPEN, Jan. 1, 2021, at 1, 4 (2021) (noting an increase in the number of Google searches for the phrase "home birth" during March 2020, including the "largest spike in searches" for the phrase since October 2016).

205. *See* JAMILA TAYLOR ET AL., CTR. FOR AM. PROGRESS, ELIMINATING RACIAL DISPARITIES IN MATERNAL AND INFANT MORTALITY 2, 16 (2019); Alice Proujansky, *Why Black Women Are Rejecting Hospitals in Search of Better Births*, N.Y. TIMES (Mar. 11, 2021), https://www.nytimes.com/2021/03/11/nyregion/birth-centers-new-jersey.html (recounting how concern about racial health disparities, along with the risk of COVID-19 exposure in hospitals, is prompting Black women to pursue community birth options); Catharine Richert, *For Black Mothers and Babies, Prejudice Is a Stubborn Health Risk*, MPR NEWS (Aug. 19, 2019, 9:00 AM), https://www.mprnews.org/story/2019/08/19/for-black-mothers-and-babies-prejudice-is-a-stubborn-health-risk (discussing Black women's experiences of racism in hospital settings and creation of a birth center in north Minneapolis that has "created a new model of culturally centered care that shows signs of success in reducing stubborn health disparities for black mothers and their babies"). Research on the Roots Community Birth Center in north Minneapolis, whose client population is

In addition, state action is needed to encourage the development of more freestanding birth centers (FBC) to increase capacity for community birth in underserved areas. In particular, the nine states where FBCs are unregulated or prohibited should enable birth center licensure, which will increase access to community birth by expanding its availability and enabling Medicaid reimbursement.[206] States should also repeal certificate of need requirements and other regulatory requirements that impede the creation of new FBCs without benefiting public health and safety or containing health care costs. Research shows that greater access to and integration of midwives into mainstream maternity care is associated with better health outcomes for birthing people and infants. As such, regulatory reform to promote midwifery, including midwife-led birth centers, is an important component of broader efforts to reduce maternal mortality in the United States.[207]

More immediately, states should embrace temporary fixes that increase access to community birth during COVID-19 (and could be replicated in future crises), including through relaxation of regulatory barriers to midwifery practice and the operation of non-hospital birthing sites. Midwives should be included in the temporary suspension of licensing laws to enable all credentialed midwives to practice without sanction. For example, the state of New York enacted a version of this temporary suspension by means of an executive order that permits midwives licensed in another state (and in good standing) to practice midwifery in New York without sanction related to lack of licensure.[208] Because New York law recognizes only CMs and CNMs, however, CPMs in New York who do not

approximately fifty percent Black, shows higher levels of patient satisfaction than among women of color who gave birth in hospitals. *Id. See generally* Rachel R. Hardeman, *Roots Community Birth Center: A Culturally-Centered Care Model for Improving Value and Equity in Childbirth*, HEALTHCARE, Mar. 2020.

206. TAYLOR ET AL., *supra* note 205, at 16, 17.

207. *See Mapping Integration*, *supra* note 162, at 10–12.

208. *See, e.g.*, N.Y. Exec. Order No. 202.11 (Mar. 27, 2020). This order was extended by Executive Order No. 202.79 until Jan. 1, 2021. N.Y. Exec. Order No. 202.79 (Dec. 2, 2020). *But see Temporary License to Health Care Practitioners Not Licensed in Pennsylvania to Be Expedited During Coronavirus Emergency*, PENN. DEP'T OF STATE (Mar. 18, 2020), https://www.dos.pa.gov/Documents/2020-03-18-Temporary-Licenses-Out-of-State-Practitioners.pdf (showing that, in contrast, Pennsylvania specifically exempted nurse-midwives from the provision of temporary licenses to out-of-state practitioners). In August 2020, legislation was introduced in Pennsylvania to temporarily license CPMs during the pandemic, but the bill stalled in committee. Pennsylvania H.B. 2747 (introduced Aug. 6, 2020). *See also* Hubbard, *supra* note 79 (discussing failed legislative effort in Pennsylvania).

States have also temporarily suspended specific regulatory provisions that apply to midwives in order to ease the burden on midwives during the pandemic. *See, e.g.*, *Suspension of Regulations Concerning Certified Nurse Midwives*, PENN. DEP'T OF STATE (Mar. 20, 2020), https://www.dos.pa.gov/Documents/2020-03-20-COVID19-Nurse-Midwives.pdf (suspending requirement that collaborative agreement be filed with State Board of Medicine prior to practicing midwifery and suspending re-entry requirements for inactive CNMs, among others).

hold a license elsewhere are not able to contribute their skills lawfully during the pandemic.[209]

Executive action should also require inclusion of midwives in private and public insurance programs to ensure access to community birth regardless of income level or insurance status. While such changes may not lead directly to permanent licensure, they do set the stage for a broader reform agenda, as it may be harder for opponents to object to expanded midwifery practice once midwives have already been operating under more permissive conditions.

Another temporary action that expands access to community birth is executive action to create "birthing surge sites," which are temporary facilities associated with—but located outside of—hospitals, staffed by licensed providers to care for non-COVID-19-infected pregnant people while reducing the risk of exposure.[210] This could include converting unused space in existing licensed health care facilities or using rooms in hotels located near hospitals in order to equip the surge site quickly and enable seamless transfer for patients who develop complications during labor and need more specialized care in the hospital.[211] New York State created a mechanism for establishing birthing surge sites through executive action, approving the Brooklyn Birthing Center and Refuah Health Center, while inviting applications for others.[212] Such action recognizes the value of keeping healthy pregnant people out of hospitals and enabling more childbearing people to select the birth site where they feel safest.

Third, states should explore policy initiatives to encourage interprofessional collaboration between midwives and physicians in order to reduce anti-midwife bias, better address maternity care workforce shortages, and achieve better maternal and infant health outcomes, both during times of health crisis and non-crisis periods. In locales where there is distrust or hostility between physicians or midwives, the cultivation of true interprofessional collaboration built on mutual respect will require culture change. Interested stakeholders might look to the Birth Summits convened by the Birth Place Lab at the University of British

209. *See Analysis of New York Midwifery Law Related to Executive Order No. 202.11 Issued by Governor Cuomo on March 27, 2020*, BIRTH RTS. BAR ASS'N (Mar. 30, 2020), https://birthrightsbar.org/resources/Documents/Analysis%20of%20NY%20Exec%20Order%20March%2027,%202020.pdf.

210. Press Release, N.Y. State, Governor Cuomo & COVID-19 Maternity Task Force Chair Melissa DeRosa Announce Increased Access to Midwife-Led Birth Centers Amid COVID-19 Pandemic (June 16, 2020).

211. *See generally Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 30, 2020), https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient (stating that, per CMS's temporary rules, hospitals can transfer patients to outside facilities, including hotels, so that inpatient beds can be used for COVID-19 patients).

212. N.Y. State, *supra* note 210.

Columbia for models of successful facilitation and other best practices.[213] Such efforts could start with investment in a collaborative approach to maternity care contingency planning for future health crises, drawing on lessons from the COVID-19 pandemic and the respective strengths of both obstetrics and midwifery. Promoting interprofessional collaboration between midwives and physicians is an essential part of tackling the maternal mortality crisis and addressing racial disparities in maternal and infant health.

VII. CONCLUSION

During the pandemic, many pregnant people pursued transfer to an out-of-hospital midwifery practice. Not only did they wish to minimize risk of COVID-19 exposure, but many pregnant people were also motivated to avoid the restrictive COVID-19 policies many hospitals implemented, including limiting support people and separating newborns from their parents in the event of a suspected or confirmed positive COVID-19 test result. These burdensome policies were the result of hospital administrators and health care providers doing their best under emergency circumstances to protect the health and safety of staff and patients with limited information about the impact of COVID-19 on pregnancy and about the disease itself. However, as clinicians, ethicists, and public health experts study the United States' COVID-19 response, they should consider carefully the inequities caused or exacerbated by prevention measures when planning for future health crises—especially for people of color who are at greater risk of experiencing mistreatment during childbirth and of suffering adverse health outcomes,[214] making the support of partners and doulas, as well as immediate bonding and breastfeeding time, all the more important.

Although such hospital policies were designed to be temporary, health experts predict that many COVID-19-inspired changes to the practice of medicine will persist after the pandemic wanes.[215] In the maternity care context, this may include continued growth in community birth, as more pregnant people seek care under the midwifery model, especially people of color whose experiences with racism and bias in medical settings make out-of-hospital midwife-attended birth particularly appealing.[216] As COVID-19 took hold,

213. *See, e.g.*, LARRY LEEMAN, BUILDING BRIDGES FROM BIRTH CENTER TO HOSPITAL: TRANSFER AND COLLABORATION 14 (2014) ("We believe that collaboration within an integrated maternity care system is essential for optimal mother-baby outcomes . . . . When ongoing inter-professional dialogue and cooperation occur, everyone benefits.").

214. TAYLOR ET AL., *supra* note 205, at 1.

215. *See, e.g.*, Sharp, *supra* note 59.

216. *See* Daviss et al., *supra* note 55, at 12 (characterizing the pandemic as a "catalyst" and "pivotal moment" in ongoing efforts to expand access to community birth); Monteblanco, *supra* note 204, at 3 (arguing the COVID-19 pandemic is a "focusing event" that "offers an excellent opportunity for community midwives and their advocates to lobby for policy changes"); Theresa E. Gildner & Zaneta M. Thayer, *Maternity Care Preferences for Future Pregnancies Among United*

many pregnant people discovered that they could not find an available midwife because area practices were full to capacity or there simply were no midwives practicing locally.[217] In this way, the pandemic highlighted the serious gaps in access to midwifery care across the U.S., even in non-pandemic times. Policymakers should act promptly to remedy the flaws in pregnancy and childbirth-related data collection, license all credentialed midwives and reform restrictive regulations on midwifery practice and freestanding birth centers in order to expand access to community birth, and develop creative ways to cultivate interprofessional cooperation and collaboration between midwives and physicians.

A central tenet of the reproductive justice framework calls for "center[ing] the most marginalized" in order to achieve reproductive justice more broadly because "[o]ur society will not be free until the most vulnerable people are able to access the resources and full human rights to live self-determined lives."[218] Centering the needs of Black women and other pregnant people of color in the push for structural change to the maternity care system during the pandemic and beyond will result in the reduction of racial health disparities that harm so many birthing people and their families, and achieve safer and healthier birth for all.

States Childbearers: The Impacts of COVID-19, FRONTIERS SOCIO., Feb. 18, 2021, at 1, 1 (finding six percent of respondents reported that experiences during the pandemic inspired a new preference for community birth during future pregnancies but over one-third of them "expected limitations in their ability to access these services," such as provider shortages or lack of insurance coverage). If an additional six percent of the nearly four million births each year took place at home or in FBCs, it would be impossible for the current midwifery workforce to satisfy demand for community birth.

217. *See, e.g.*, Samantha Schmidt, *Pregnant Women Are Opting for Home Births as Hospitals Prepare for Coronavirus*, WASH. POST (Mar. 20, 2020, 7:00 AM), https://www.washingtonpost.com/dc-md-va/2020/03/20/pregnant-women-worried-about-hospitals-amid-coronavirus-are-turning-home-births-an-alternative/.

218. *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice (last visited Feb. 19, 2020).