Seeking Safety While Giving Birth During the Pandemic

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SEEKING SAFETY WHILE GIVING BIRTH DURING THE PANDEMIC

ELIZABETH KUKURA*

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. 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. 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. 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 “reify] 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.

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 complications7 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

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4. E.g., Freytas-Tamura, supra note 2.
6. See infra Part II.
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. 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. 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. 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, 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 Midwives, limit access to midwife-attended care.

11. See infra Part IV.
Midwives in fourteen states, have resulted in a limited number of community-based midwives available to care for pregnant people. 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. 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. 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.”

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. However, this conclusion was


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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{20} At the same time, there were reports of placental abnormalities,\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{25} Other data emerged outside the

\begin{enumerate}
\item \textsuperscript{18} \textit{Id.}
\item \textsuperscript{19} Martin, \textit{supra} note 16.
\item \textsuperscript{20} \textit{Id.}
\item \textsuperscript{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. \textit{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. \textit{Id.}
\item \textsuperscript{22} Martin, \textit{supra} note 16.
\item \textsuperscript{23} \textit{Id.}
\item \textsuperscript{24} \textit{Id.}
\item \textsuperscript{25} \textit{Id.}
\end{enumerate}
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.  

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. 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. 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. 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.

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. 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. 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. Looking ahead, a number of research teams around the country have launched larger-
scale studies of COVID-19 and pregnancy risk, though the results of these efforts will not be available for some time.  

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. 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. 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. 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. 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.


36. See Preston, supra note 35.


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).\textsuperscript{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.\textsuperscript{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.\textsuperscript{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,\textsuperscript{42} Native women dying at 4.5 times the rate of pregnant non-Hispanic White women,\textsuperscript{43} and Black infants suffering disproportionately high rates of low birth weight, prematurity, and mortality.\textsuperscript{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,

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


\textsuperscript{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).


\textsuperscript{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. 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. 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.

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—especially for minority populations who are disproportionately contracting and dying from COVID-19.

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. In non-

45. See Kakura, 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”).


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

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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)).
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

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).


58. 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).

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{64} Birth doulas are non-medical support people who provide culturally appropriate emotional, physical, and informational support during pregnancy and childbirth.\textsuperscript{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.\textsuperscript{66} The medicalization of maternity care in the United States—
with nearly one in three deliveries resulting in a cesarean and high rates of other interventions during labor and delivery—has not curbed the country’s current maternal mortality crisis and, in fact, may be contributing to unnecessary morbidity and mortality. 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. While insurance coverage of doula services remains limited, doulas are not a luxury only wealthy women seek, as they are sometimes characterized. With increasing recognition of the value doula support provides, some states have moved to establish Medicaid coverage for doula services. 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.


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.


73. See e.g., Astie 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. 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. 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. 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.” 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; 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.
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. 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.

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. 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, 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. 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).
impact access to the neonatal intensive care unit (NICU) for families with newborns who need specialized care.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.”\textsuperscript{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”).

\textsuperscript{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”).

\textsuperscript{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).


\textsuperscript{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).

\textsuperscript{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, 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. 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.

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. 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.

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

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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).


93. Sharp, supra note 59.

authorities early in the pandemic, 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.” 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. 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.

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. In particular, research supports the importance of the “golden hour” for optimal health outcomes for the maternal-infant dyad. 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.
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.\textsuperscript{102} Delayed latching, even if the parent expresses milk to feed with a bottle, may interfere with the ability to breastfeed later.\textsuperscript{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.\textsuperscript{104} In addition to the adverse health impacts, newborn separation requires space, staff, and equipment that were already in short supply in many hospitals.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{109} The CDC similarly updated its guidance on August 3, 2020, emphasizing the significance
of autonomy in maternity care decision-making. 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. 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.

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. 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. Because people of color already have worse maternal and infant

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%26E2%80%8A6 (reporting federal investigation found hospital violated patients’ rights).
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

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

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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.


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).


128. Id.

129. Id.

130. Id.

131. Id.


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

instrumental or surgical deliveries.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{141} A 2009 study found that women who delivered at home with midwives had half as many

\begin{footnotes}


\footnote{139. Id. at 20, 22–24.}

\footnote{140. Id. at 21, 23.}

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/common
health/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

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
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
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
155. See Nina Martin et al., Lost Mothers, PROPUBLICA (July 17, 2017),
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. This is particularly true for pregnant people who have experienced mistreatment by maternity care providers previously—who are disproportionately women of color—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. 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. 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. As a result of the historical suppression of midwives 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.


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,\textsuperscript{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.\textsuperscript{165} During the pandemic, as more pregnant people sought community birth options in order to minimize risk of COVID-19 exposure,\textsuperscript{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).\textsuperscript{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.\textsuperscript{168} As of February 2019, there were 12,218 CNMs practicing in the United States.\textsuperscript{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.\textsuperscript{170} As of October 2020, there were 2500 CPMs with active certification in...
the United States. 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. As of February 2019, there were 102 CMs in the United States, and they were eligible for licensure in only six states.

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; (2) restricted autonomy and limited scope of practice for CNMs, CPMs, and CMs in various jurisdictions; and (3) regulatory hurdles to establishing more freestanding birth centers, including the lack of state licensure for birth centers and various burdensome regulatory requirements.

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. 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. 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, with physician opposition resulting from concern about economic competition or other anti-midwife bias. Without full licensure, there will continue to be an undersupply of CPMs to meet the demand.

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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.
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/.
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 “DEM” to refer to all direct-entry midwives—CPMs and CMs—collectively.
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.

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,


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).


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 NEWBORN EVALUATION IV (Oct. 2018).

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.
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/6561318 002/ (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”).
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, 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. 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. It collects comprehensive data but uses a straightforward two-page form to collect data in order to ease the burden on clinicians. 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 women.

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.\textsuperscript{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.\textsuperscript{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\textsuperscript{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.\textsuperscript{205}

\textsuperscript{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.").

\textsuperscript{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).

\textsuperscript{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
(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).

\textsuperscript{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),
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-stub
born-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.


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


212. N.Y. State, supra note 210.
Columbia for models of successful facilitation and other best practices.\textsuperscript{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.

\textbf{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,\textsuperscript{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.\textsuperscript{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.\textsuperscript{216} As COVID-19 took hold,
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.

