IN THE
SUPREME COURT OF MISSOURI

SC88783

MISSOURI STATE MEDICAL ASSOCIATION, et al.,

Respondents

v.

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

Appellants.

Appeal from the Circuit Court of Cole County
The Honorable Patricia S. Joyce, Judge

AMICUS CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

Leonard A. Nelson IL Bar #2032384
Barat S. McClain IL Bar #6205081
American Medical Association
515 N. State Street
Chicago, IL 60610
Phone No. (312) 464-4600
Fax No. (312) 464-5846

Johnny K. Richardson #28744
Brydon, Swearengen & England P.C.
The Hammond Building
312 East Capitol Avenue
Jefferson City, MO 65102
Phone No. (573) 635-7166
Fax No. (573) 635-0427
E-mail: Johnnyr.@brydonlaw.com

ATTORNEYS FOR AMICUS CURIAE AMERICAN MEDICAL ASSOCIATION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Federal Statutes

State Constitution

State Statutes

Miscellaneous

STATEMENT OF AMICUS INTEREST

Amicus curiae American Medical Association ("AMA"), an Illinois non-profit corporation, represents approximately 240,000 physicians, medical residents, and medical students who practice throughout the United States, including Missouri. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.

With the consent of both Appellants and Respondents, the AMA submits this brief on its own behalf and as a representative of the Litigation Center of the AMA and the State Medical Societies. The Litigation Center is an unincorporated association among the AMA and all 50 state medical societies as well as the Medical Society of the District of Columbia. Established in 1995, the purpose of the Litigation Center is to advance AMA policies through the American legal system.

Amicus curiae AMA is concerned generally about unregulated midwife practice in the United States. *Amicus* is particularly concerned about Missouri's recently enacted midwife provision, Mo. Rev. Stat. §376.1753, which is at issue here. Not only did the procedures employed in the passage of this law violate various provisions of the Missouri Constitution, but *Amicus* believes that the midwife provision also presents a significant threat to the health (indeed, lives) of pregnant women and babies in Missouri.

Amicus submits this brief to inform the Court of the health and welfare ramifications of Mo. Rev. Stat. §376.1753. *Amicus* believes that the brief's discussion of

empirical evidence demonstrating both the frequency of complications during labor and delivery and the increased risks associated with births outside of hospitals, as well as the significance of the inclusion of women in active labor within the scope of the federal Emergency Medical Transfer and Active Labor Act (EMTALA), 42 U.S.C. §1395dd, will help the Court better appreciate those ramifications. *Amicus* also submits this brief to advise the Court of the inconsistencies between §376.1753 and the Missouri laws pertaining to physician licensure.

ARGUMENT

I. THE MISSOURI MIDWIFE LAW POSES PROFOUND RISKS TO THE HEALTH AND WELFARE OF MISSOURI'S CITIZENS.

This law was introduced and passed in blatant violation of Missouri Constitution art. III §§21 and 23, whose general purposes include avoidance of surprise through surreptitious amendments. *See Missouri Ass'n of Club Executives, Inc. v. State*, 208 S.W.3d 885, 888 (Mo. 2006) (en banc) (invalidating addition to bill on next-to-last day of legislative session, which was textbook example of legislative log-rolling); *National Solid Waste Mgm't Ass'n v. Director of Dep't of Natural Resources*, 964 S.W.2d 818, 820 (Mo. 1998) (invalidating "last minute amendment about which even the most wary legislators could hardly have given their considered attention and about which concerned citizens likely had no input"). Moreover, Missouri Constitution art. IV §40(a) provides that "[t]he health and general welfare of the people are matters of primary concern." The very core of this concern is implicated by the midwife law's allowance of unregulated treatment of pregnancy and birth by those who are inadequately trained and unlicensed.

A. Empirical studies conclusively demonstrate that home childbirths can be substantially more dangerous than hospital childbirths.

Although pregnancy and childbirth are sometimes blithely described as "natural processes," they often present sudden health crises. Such emergency situations require the expertise of a physician and/or a certified nurse-midwife, as well as the technological and staffing resources of a hospital. Most maternal deaths and serious complications

occur during labor and delivery. I. Danel, M.D., M.S., et al., *Magnitude of Maternal Morbidity During Labor and Delivery: United States*, 1993-1997, 93 Amer. J. Pub. Health 631 (Apr. 2003), *available at* http://www.ajph.org/cgi/content/full/93/4/431.

Unregulated midwives' claims that pre-screening eliminates high-risk pregnancies from their care are misguided and symptomatic of an inappropriate emphasis on the "soft," "psychosocial" aspects of childbirth over the medical realities. Similarly wrongheaded are Appellants' specious arguments that "birth will occur regardless of whether a physician is involved" and that §376.1753 "involves the expansion of a woman's options" (State of Missouri's Brief, at 22) by providing "meaningful freedom of choice" (Friends of Missouri Midwives Brief, at 39, 41).

The obscurely worded one-sentence statutory provision at issue here exempts non-nurse-midwives from all legal regulation. Not only are there substantial health risks associated with a lay-attended homebirth but, tellingly, any other healthcare provider involved with childbirth is subject to administrative oversight. There is no justifiable rationale for the legislature having chosen to permit lay midwifery without also providing for regulatory oversight to protect the public health. The law fails to address fundamental questions of how the "tocologists" legally would interact with other healthcare providers and what kinds of oversight should regulate their qualifications and activities.

The clear preponderance of medical literature recognizes that homebirths are more dangerous than hospital births. *E.g.*, J.W.Y. Pang, M.D., et al., *Outcomes of Planned Home Births in Washington State: 1989-1996*, 100 Obstetrics & Gynecology 253 (2002), *available at* www.greenjournal.org/cgi/content/full/100/2/253. That study showed that

the incidence of neonatal death was *twice as high* (3.5/1,000) for planned homebirths as for hospital births (1.7/1,000). *Id.* at 6. Moreover, first-time mothers who plan a homebirth are at greater risk of prolonged labor and postpartum hemorrhage and their infants are at greater risk of neonatal respiratory distress. *Id*. at 5. Additionally, infants whose births are planned at home are more likely to die from congenital heart disease which, like respiratory distress, is more likely to be prevented in a hospital setting. *Id.* at 6.

Further, an analysis specifically targeted toward Missouri homebirths found that neonatal mortality was elevated for both planned and unplanned homebirths compared with physician-attended hospital births. W.F. Schramm, D.E. Barnes, R.N. & J.M. Bakewell, *Neonatal Mortality in Missouri Home Births, 1978-84*, 77 Amer. J. Pub. Health 930 (1987) *available at* http://www.ajph.com/cgi/reprint/77/8/930. The risk of neonatal death in planned homebirths was *twice* that of physician-attended hospital births. *Id.* at 932. Nearly all of the increased death rate in planned homebirths was attributable to lesser trained attendants. *Id.* Further, in unplanned homebirths, the neonatal death rate of infants weighing at least 1500 grams (3.3 pounds) was approximately *five-and-a-half times* that of hospital births. *Id.*

A recently published British article by a professor of health psychology highlights the disconnect between the idealistic advocacy of homebirth proponents and the actual exigencies of pregnancy and childbirth. M.L. Crossley, *Childbirth, Complications and the Illusion of "Choice": A Case Study*, 17 Feminism & Psychology 543 (2007). As the author points out, a sharp discrepancy may lie between a pregnant woman's expectations

when rooted in "the rhetoric of choice surrounding contemporary childbirth" and the frequent need for medical intervention to ensure safe delivery. *Id.* at 560. While popular ideology may uncritically advocate a "natural" approach towards childbirth, in reality a woman's ability to truly exercise "choice" in the birthing process may be minimal, because of the emergence of medical crises. *Id.* For example, in Crossley's own pregnancy, overdue at 41 weeks and experiencing increasingly high blood pressure, continuous migraines, nausea, swelling and exhaustion, she was admitted to hospital where she had an emergency cesarean section, despite her earlier resolve to have a "natural" homebirth. *Id.* at 548, 552. Indeed, as a general matter, a host of life-threatening complications can arise during labor (such as breech positioning or an umbilical cord wrapped around the baby's neck) which can pose sudden, unexpected and frightening danger to the mother and infant.

Midwife advocates often recite the canard that homebirths are as safe as, or even safer than, hospital births. In particular, they cite a study published in 2005 in the British Medical Journal (BMJ) that concluded that "planned home birth" for "low risk" women in North America was associated with lower rates of medical intervention than low risk hospital births in the United States. K.C. Johnson & B. Daviss, *Outcomes of Planned Births With Certified Professional Midwives: Large Prospective Study in North America*, 330 British Medical Journal 1416 (2005) (*"North America Outcomes"*), *available at* www.bmj.com/cgi/content/full/330/7505/1416?ehom. That study also concluded that

such homebirths had intrapartum (i.e., occurring during labor) and neonatal death rates similar to low risk hospital births. *Id*.[1]

The BMJ study has been criticized, however, because among other things: (1) it did not include planned homebirth transfers to hospital as a medical intervention (Posting of Y. Sehgal, Family Physician, Sioux Lookout, Ontario, Rapid Responses for Johnson and Daviss, 330 (7505) 1416, at 6 (*"Rapid Responses"*)), *available at* www.bmj.com/cgi/eletters/330/7505/1416; (2) it did not compare home delivery and hospital delivery outcomes (Posting of David A. Rivera, Physician, Lombard, IL *Rapid Responses,* at 7, noting that "low risk can become high risk in a heartbeat"); and (3) the co-authors are biased homebirth advocates: Johnson is the head of the Midwives Alliance of North America (MANA) Statistics and Research Committee, Daviss is a homebirth midwife, and their study was funded by the homebirth advocacy group, Foundation for Advancement of Midwifery. Comments of Amy Tuteur, M.D., "*The Truth About Midwifery," available at* truthaboutmidwifery.com/medicalstudies.htm; *see* Foundation for the Advancement of Midwifery--Grants, *available at* www.formidwifery.org/grants.htm (acknowledging Johnson's and Daviss' roles in MANA's certified professional midwife statistics project).

[1] The BMJ study's authors conceded that their study and its conclusions were limited by their inability to develop a workable design from which to collect a national prospective low-risk group of hospital births in order to compare morbidity (i.e., disease) and death directly. *North America Outcomes*, at 5.

Even the BMJ study's authors acknowledge these criticisms. In that light, they have provided revised statistics based on more accurate analysis, using data published in 2002.[2] Specifically, Johnson & Daviss revised downward the 2000 neonatal death rate in hospital to 0.9/1,000 live births, as compared with a neonatal death rate in homebirths of 2.6/1,000. Thus revised, the homebirth death rate is shown to be *almost triple* that of the hospital death rate for low risk white women giving birth at term (i.e., at least 37 weeks pregnant). Johnson & Daviss, BMJ Home Birth Study Questions, Understanding Birth Better, *available at* http://understandingbirthbetter.com/section.php?ID=31&Lang=En&Nav=Section. Most importantly, of course, neither the BMJ study nor any other responsible peer reviewed article suggests that homebirthing should be undertaken without the assistance of a trained professional. Thus, any use of homebirthing is, from a medical viewpoint, at least questionable. Homebirthing under the auspices of an unlicensed and unregulated layperson is completely unsupportable.

[2] Infant Mortality Rates, Live Births, and Infant Deaths by Selected Characteristics and Specified Race of Mother: United States, 2000 linked file, 50, No. 12, CDC National Center for Health Statistics, at 11, *available at* www.cdc.gov/nchs/linked.htm.

B. The gravity of the childbirth process is underscored by the express inclusion in the Emergency Medical Transfer and Active Labor Act (EMTALA) of a pregnant woman's active labor as a medical condition mandating hospital medical screening and stabilization treatment.

When complications develop during a homebirth, transport to an emergency room often occurs. The homebirth then becomes a hospital statistic, masking the frequency of homebirth crises.[3] Moreover, last-minute emergency transfers of laboring women with complications place an additional burden on emergency department physicians and other members of hospital staffs who often are already over-stretched.

The Emergency Medical Transfer and Active Labor Act (EMTALA), 42 U.S.C. §1395dd, provides that hospitals that receive Medicare payments and have an emergency

[3] E.g., *North America Outcomes* at 1, 3. (12.1% of women intending home delivery when labor began were transferred to hospital while in labor or after delivery). *See* C. Van Way, M.D. (President, Missouri State Medical Association), *Pro-Con: Should the New Missouri Midwifery Law Stand? No*, Kansas City Star, July 15, 2007, *at* B10 ("*Pro-Con"*) (noting that emergency transfer masks the frequency of homebirth crises and that Missouri's midwife law is seriously flawed because, among other things, it contains neither a provision requiring collaboration between physicians and lay midwives nor a provision for an emergency transfer agreement with a hospital capable of handling obstetrical emergencies).

department must provide at least minimal medical services to a woman in active labor who seeks such attention, regardless of the woman's ability to pay for those services. Under 42 U.S.C. §1395dd(a) and (b), these obligations include "appropriate medical screening" and "stabilization."[4] EMTALA includes "a pregnant woman who is having contractions" within its definition of an applicable "emergency medical condition" when there is inadequate time to effect safe transfer to another hospital prior to delivery, or when a transfer may pose a threat to the health and safety of the unborn child. 42 U.S.C. §1395 dd(e)(1)(B)(i-ii). *Burditt v. U.S. Dep't of Health and Human Services,* 934 F.2d 1362, 1369 (5th Cir. 1991). EMTALA's requirements thus acknowledge the seriousness with which Congress regards the childbirth process, underscoring that medical oversight is necessary to optimize the likelihood of a safe delivery and the mother's and child's well-being. Because the new midwife law would allow the care of a woman in labor by an unsupervised, unlicensed and unregulated lay midwife, it flouts Congressional intent in enacting EMTALA and imprudently thrusts on physicians the responsibility to treat a complication resulting from a lay midwife's inability to do so.

[4] The former obligates emergency rooms to provide an appropriate medical screening in order to determine whether the individual has an emergency medical condition. If such a condition is found to exist, the hospital must provide stabilization treatment before transferring the individual. *Nolen v. Boca Raton Community Hospital, Inc., et al.*, 373 F.3d 1151, 1154 (11th Cir. 2004) (citation omitted).

C. Licensed and certified nurse-midwives augment and complement physicians' treatment of obstetrical patients.

Certified nurse-midwives can and do play a significant role in providing prenatal counseling and examinations, assistance during labor and delivery, as well as postnatal support. In Missouri, as throughout the United States, nurse-midwives complete both a rigorous undergraduate academic program that leads to a degree and licensing as a registered nurse (R.N.) and intensive post-graduate training in obstetrics that leads to certification. To become certified, a nurse-midwife must graduate from a nurse midwifery program accredited by the ACNM and pass a national certification exam. *See* http://www.allnursingschools.com/faqs/cnm.php. Ninety-two certified nurse-midwives are currently licensed in Missouri. Missouri Division of Professional Registration, *available at* http://pr.mo.gov/licensee-search-results.asp?passview=1.[5]

Mo. Rev. Stat. §334.104 provides that a physician may enter into collaborative practice arrangements with registered professional nurses. As registered nurses, indeed advanced-practice registered nurses, nurse-midwives are a category of registered professional nurses within the ambit of §335.076. Such collaborative agreements are subject to rules jointly promulgated by the Missouri State Board of Registration for the

[5] Nationally, there are more than 6,000 certified nurse-midwives. ACNM Membership By Category 2001-2006, *available at* www.midwife.org/memberFiles/news/The_State_of_ACNM_2007.pdf.

Healing Arts (pursuant to Mo. Rev. Stat. §334.125) and the Missouri Board of Nursing (pursuant to Mo. Rev. Stat. §335.036). Under collaborative practice arrangements, nurse-midwives may assist a pregnant woman with her labor and delivery at a hospital, birthing center, or at home. *Pro-Con, supra.* Moreover, under §334.104, certified nurse-midwives in Missouri are authorized to prescribe medications.[6]

However, the case at hand involves something quite different from the situation contemplated under the tightly regulated regimen of §334.104. The challenged law would allow individuals who lack the training that is a prerequisite to certified nurse-midwifery licensure to practice unregulated midwifery[7], all without a physician's supervision or collaboration. Although allied health professionals have an important role to play in providing safe, effective, and economical health care, the practice of midwifery

---

[6] Such collaborative practice rules take effect after approval by a majority vote of a quorum of each board. Mo. Rev. Stat. §334.104.3. Any rules relating to dispensing or distribution of prescription medications or devices are subject to the state board of pharmacy's authority. *Id.* On a national level, the American College of Nurse-Midwives (ACNM) is a party, along with the American College of Obstetricians and Gynecologists (ACOG), to a Joint Statement of Practice Relations, *available at* www.midwife.org/siteFiles/position/Joint_Statement_05.pdf.

[7] Indeed, §376.1753 is so broad in its potential application that it could permit unregulated midwives to provide nearly any service related to pregnancy, including cesarean sections, epidural anesthesia and even terminations.

by those without adequate preparation, irrespective of whether they are called "certified professional midwives," "direct-entry midwives" or "lay midwives"[8] poses a threat to the health of pregnant women and their infants.

II. MISSOURI PHYSICIANS HAVE A LEGITIMATE AND PROTECTABLE CONCERN THAT THEIR LICENSURE MAY BE PLACED IN JEOPARDY BY THE MIDWIFE LAW.

Section 334.104's allowance of collaborative practice agreements between physicians and certified nurse-midwives provides a particular, medically prudent exception to §334.010's general prohibition against a non-physician engaging in the practice of midwifery. Mo. Rev. Stat. §334.010.1 provides:

> It shall be unlawful for any person not now a registered physician within the meaning of the law to practice medicine or surgery in any of its departments, to engage in the practice of medicine across state lines or to profess to cure and attempt to treat the sick and others afflicted with bodily or mental infirmities, *or engage in the practice of midwifery in this state*, except as herein provided.

Id. (emphasis supplied). The italicized provision was found constitutional by this Court in *State ex rel. Mo. State Bd. of Registration for Healing Arts v. Southworth*, 704 S.W.2d 212 (Mo. 1986).

[8] "Certified professional midwives" are recognized by the North American Registry of Midwives (NARM) but do not have the degree of training of certified nurse-midwives. "Direct-entry midwives" or "Lay Midwives" are neither registered nurses nor certified.

By contrast, though, and as Judge Joyce recognized, Mo. Rev. Stat. §376.1753 would directly conflict with the broader Missouri statutory framework to which physicians are subject. The Missouri State Board of Registration for the Healing Arts may discipline any physician for:

> [a]ssisting or enabling any person to practice or offer to practice any profession licensed or regulated by [Chapter 334, which governs physicians and surgeons] who is not registered and currently eligible to practice pursuant to this chapter; or knowingly performing any act which in any way aids, assists, procures, advises, or encourages any person to practice medicine who is not registered and currently eligible to practice pursuant to this chapter.

Mo. Rev. Stat. §334.100.2(10).

Missouri physicians have a legitimate and protectable interest in ensuring that their medical licenses will not be placed at risk by §376.1753. Under the vague wording of that provision, a physician would violate §334.100.2 by coordinating the care of a pregnant woman and her baby with an unlicensed, unregulated midwife. Indeed, the possibility of such a result underscores the dangerous policy ramifications of this midwife law. *See*, e.g., *State ex rel. Missouri State Board of Registration for the Healing Arts v. Hartenbach*, 768 S.W.2d 657, 659 (Mo. Ct. App. 1989) (a licensed nurse's permission to carry out a physician's standing order or protocol does not suggest that a physician has authority to issue such orders and protocols without regard to physician's own licensing constraints). *See also* Edward P. Richards, *The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board*

Regulation of Physicians in ERISA-Qualified Managed Care Organizations, 8 Ann. Health L. 201, 235-36 & n.109 (1999) (noting "profound legal difference between physician-directed care and nursing care" and in that regard, medical licensing boards' responsibility to assure that physicians are in charge of patient care, including the supervision of nurses).

CONCLUSION

Mo. Rev. Stat. §376.1753, the midwife provision, not only offends numerous provisions of the Missouri Constitution, it also offends the sound public policy of the State of Missouri. *Amicus* American Medical Association therefore urges the Court to affirm the decision of the Circuit Court of Cole County and to enter an order holding that Mo. Rev. Stat. §376.1753 is invalid.

Respectfully submitted,

Leonard A. Nelson
Illinois Bar #2032384
Barat S. McClain
Illinois Bar #6205081
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
Telephone: (312) 464-4600
Fax Number: (312) 464-5846

Johnny K. Richardson
Missouri Bar #28744
BRYDON, SWEARENGEN & ENGLAND P.C.
The Hammond Building
312 East Capitol Avenue
Jefferson City, MO 65102
Telephone: (573) 635-7166
Facsimile: (573) 635-0427

_____
COUNSEL FOR AMERICAN MEDICAL ASSOCIATION

CERTIFICATE OF COMPLIANCE

The undersigned herby certifies that this brief contains the information required by Mo. Sup. Ct. R. 55.03, complies with Mo. Sup. Ct. R.84.06 (b) and contains 3811 words, excluding the parts of the brief exempted. The undersigned also hereby certifies that the brief has been prepared in proportionately-spaced typeface using Microsoft Word in 13 pt. Times New Roman font, and includes a compact disk in Microsoft Word format, which has been scanned for viruses and is virus free.

_____

Counsel for American Medical Association

CERTIFICATE OF SERVICE

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

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

ATTORNEYS FOR APPELLANT STATE OF MISSOURI

James B. Deutsch
Marc H. Ellinger
Jane A. Smith
Thomas W. Rynard
Blitz, Bardgett & Deutsch, L.C.
308 East High Street, Suite 301
Jefferson City, MO 65101

ATTORNEYS FOR APPELLANTS
FRIENDS OF MISSOURI MIDWIVES, ET AL.

Harvey M. Tettlebaum
Robert L. Hess II
Husch & Eppenberger
235 East High Street, Suite 200
Jefferson City, MO 65101

ATTORNEYS FOR RESPONDENTS

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

ATTORNEY FOR RESPONDENT MISSOURI STATE
MEDICAL ASSOCIATION

_____
Attorney for American Medical Association