IN THE SUPERIOR COURT OF FULTON COUNTY
STATE OF GEORGIA

JAMARAH AMANI, TAMARA TAITT, and SARAH STOKELY, Plaintiffs, v. STATE OF GEORGIA, Defendant.	Civil Action File No. ____

INTRODUCTION

1. Instead of integrating midwives into the state's maternity care system, Georgia maintains some of the most restrictive midwifery laws in the nation. Georgia prohibits direct-entry midwives—those trained outside the nursing profession who specialize in out-of-hospital births—from practicing midwifery altogether. It also bars certified nurse-midwives—advanced practice nurses trained in midwifery—from practicing independently by requiring a formal, written agreement with a physician that often entails paying physicians hundreds of dollars a month.

2. Jamarah Amani, Tamara Taitt, and Sarah Stokely are experienced midwives who have devoted their careers to supporting pregnant people and their families. They have spent years developing the skills necessary to care for low-risk pregnancies. Individuals and families actively seek out their expertise. Yet Georgia law threatens them with criminal and civil penalties should they provide that care in the State.

3. Georgia's Midwifery Restrictions do not advance patient safety. Extensive research shows that midwifery care is safe and effective for low-risk pregnancies, is associated with fewer

unnecessary medical interventions, and is linked to improved outcomes. Georgia's restrictions contradict that evidence and bear no rational relationship to differences in training, scope of practice, or risk. Instead, Georgia blocks qualified midwives from providing the care they are trained to deliver while doing nothing to ensure meaningful collaboration among maternity care providers or improve health outcomes.

4. In doing so, Georgia's restrictions intrude on one of life's most significant experiences: pregnancy and birth. Decisions about prenatal and postpartum care and where, how, and with whom to give birth affect not only medical outcomes but also personal autonomy, cultural practices, and family. Georgia's laws sharply limit these decisions.

5. Georgia's restrictions also reflect and perpetuate a history of excluding midwives from practice. For generations, midwives—including Black midwives across the South—were central to supporting pregnant people through pregnancy and birth. Over time, however, Georgia imposed increasingly restrictive laws as part of a broader campaign that pushed midwives out of practice, narrowed options for families, and left lasting consequences.

6. Georgia's restrictions persist even as the State faces one of the highest maternal mortality rates in the United States and a substantial shortage of maternity care providers, particularly in rural areas. These threats disproportionately endanger the lives and health of Black pregnant people and their babies.

7. Georgia's onerous and unreasonable restrictions violate core guarantees of the Georgia Constitution, including the right to pursue one's chosen profession, equal protection of the laws, and limits on the delegation of governmental power to private actors. Plaintiffs therefore seek judicial relief to bring the State into compliance with the law, restore lawful pathways for midwives to practice, and enable Georgians to access the maternity care they want and need.

PARTIES

I. PLAINTIFFS

8. **JAMARAH AMANI** is a recognized leader in midwifery and birth justice and a direct-entry midwife licensed in Florida, where she has practiced for 13 years.

9. From a young age, Amani organized around public health issues affecting Black communities, including HIV prevention, infant-mortality reduction, and access to contraception and midwifery care. After graduating from the University of Pennsylvania, Amani pursued graduate studies at Clark Atlanta University, where she researched the disproportionately high Black maternal mortality rates in the United States and Georgia. She has seen firsthand the barriers families face in accessing respectful maternal health care.

10. Amani encountered many of those barriers in her own pregnancy and birth experiences. During her first pregnancy, in Pennsylvania, she switched from a physician to a nurse-midwife after feeling rushed and unheard in prenatal appointments. She delivered in a hospital-based birth center with a nurse-midwife but received little postpartum support and struggled with breastfeeding before locating a lactation consultant on her own.

11. During her second pregnancy, in Georgia, Amani was unable to obtain midwifery care covered by Medicaid and instead received care from an obstetrician. During labor, she underwent multiple medical interventions and was repeatedly instructed to remain in bed. Hospital staff threatened her with claims that sitting or standing during labor would kill her baby, which she knew to be untrue. Although a doula helped advocate for her, the experience was distressing and traumatic.

12. Amani later had two home births in Florida with licensed midwives more respectful, supportive, and aligned with her needs. These experiences confirmed for her the value of midwifery and patient-centered care.

13. While living in Georgia—and inspired by Black "grand midwives" who historically provided most of the maternal health care across the South—Amani became close to respected elders in her community. These women carried forward traditional techniques for prenatal, pregnancy, and postpartum care and brought holistic support to communities that desperately needed it. Amani's mentors were deeply knowledgeable about pregnancy and birth. She also joined efforts to restore legal pathways for midwives to practice in Georgia. Amani was advised to pursue her midwifery training in a state that was more supportive, where she could eventually practice lawfully and openly, without the threat of criminalization.

14. Amani moved to Florida to attend the International School of Midwifery, a three-year program combining classroom instruction, clinical training, and apprenticeship. She studied pregnancy and birth physiology, prenatal assessment, labor support and delivery, postpartum and newborn care, breastfeeding support, and the recognition of conditions requiring consultation or transfer to more complex levels of care. Through training with experienced midwives, Amani participated in prenatal visits, attended births, and provided postpartum support to families, which prepared her to practice in home and birth center settings.

15. After completing her training and education, Amani hoped Georgia would reform its midwifery laws, bringing them in line with neighboring states. That would allow her to return and build career as a midwife here. Georgia did not do that.

16. After graduating and passing the national certifying exam for certified professional midwives, Amani therefore obtained her license to practice midwifery in Florida. She also became a certified lactation consultant. Amani established her midwifery practice in Florida.

17. She is now the executive director of the Southern Birth Justice Network (SBJN), which works to expand access to community-based maternal health care through training,

advocacy, and support for birth workers and families. Amani established the Mobile Midwifery Clinic, an SBJN program that helps deliver prenatal care, health education, screenings, and postpartum support directly to communities in South Florida. In her private midwifery practice, Amani works with patients from their initial prenatal visits through their birth and postpartum process—including attending births at homes and at a birth center—and trains and mentors midwives and other birth workers. Through this work, families—particularly low-income Black and Latino families—gain access to care, including home birth and birth center services, despite barriers such as cost, transportation, and limited provider availability.

18. Families seek Amani's care for a variety of reasons. Some have experienced mistreatment, coercion, or trauma in hospital settings and want a different model of care. Some seek a culturally grounded approach to pregnancy and birth or wish to continue family or community traditions of home birth. Others face barriers to care, including cost, transportation, and lack of information. Many seek her out for care that respects their autonomy and centers their needs and values. As Amani explains: "Midwives are the experts in physiologic birth. Our tools are our hands, our training, and our ability to support the emotional, spiritual, and physical aspects of birth. When people feel safe and respected, their outcomes are better."

19. Georgia's Midwifery Restrictions have interfered with Amani's ability to care for her patients. When Hurricane Irma forced Amani and her family to evacuate Florida in 2017, they sought safety in Georgia. One of Amani's patients—who was due to give birth within days—also evacuated to Georgia. Although Amani was nearby and capable of providing care under those circumstances, Georgia law prohibited her from assisting the patient and would have exposed her to criminal penalties if she had done so. As a result, the patient faced the possibility of giving birth without continuity of care from her chosen provider during an already stressful evacuation.

Ultimately, both Amani and her patient returned to Florida before the birth, and Amani did not have to choose between assisting her patient and risking criminal penalties.

20. Secretary of State Brad Raffensperger recognized Amani as an "Honorary Georgia Citizen" in 2023. She maintains strong personal and professional ties to this State, and would practice here but for the Midwifery Restrictions. Families in Georgia, including those who knew her when she lived here, contact her to ask if she can attend their births or a family member's birth as their midwife. Paradoxically, those Georgia families could, in theory, travel to Florida to access Amani's care, but Amani cannot provide that care to them in Georgia. Georgia law prohibits Amani from practicing as a midwife and subjects her to harsh penalties if she does, preventing her from practicing in the State.

21. **TAMARA TAITT** has worked in maternal, infant, and child health for 20 years. She is a direct-entry midwife licensed to practice in Florida and the executive director of Atlanta Birth Center. Taitt is also a marriage and family therapist and has held several faculty and leadership positions at midwifery education programs, helping to train and mentor future midwives.

22. After graduating from Princeton University, Taitt moved to Florida to attend Miami Dade College's Midwifery Program, a two-year program of academic and clinical training. The health sciences coursework covered anatomy and physiology, prenatal care, labor and birth management, postpartum and newborn care, breastfeeding support, and the identification of complications requiring different levels of care. In her clinical training, Taitt attended births and provided prenatal and postpartum care under the supervision of more experienced midwives, preparing her to provide care in homes and birth centers.

23. Taitt graduated from the Miami Dade College Midwifery Program, passed the

national certifying exam for certified professional midwives, and obtained her license to practice midwifery in Florida.

24. For years, Taitt provided midwifery care to families in Florida, including attending home and birth center births. Taitt opened a pregnancy and parenting resource center, The Gathering Place, and later opened Magnolia Birth House, a freestanding birthing center, which she directed and staffed as a midwife for nearly a decade. Magnolia is intentionally located in a historically Black neighborhood. There, direct-entry midwives and other providers offer comprehensive, community-based maternity care—including prenatal, birth, and postpartum services, childbirth education, and breastfeeding support.

25. Taitt's work in Florida focused on expanding access for families who have not always gotten the care they need from the healthcare system. She supported families who started pregnancy with fewer resources or had trouble getting prenatal care. Many were looking for care that understood and respected their backgrounds. Through Magnolia, Taitt helped build an approach to care that centers respect, strong support, and healthy outcomes for both parents and newborns.

26. In Taitt's experience, families seek midwifery care because it offers a model that is not one-size-fits-all but instead centers their autonomy, values, and individual needs during a deeply significant life event. Many want to be active participants in their care. Others have had prior experiences in healthcare settings where they were dismissed or mistreated. Families also turn to midwifery care after learning that, in low-risk pregnancies, it can improve both outcomes and the overall experience of pregnancy and birth.

27. Taitt now lives in Georgia. Since 2023, she has served as the executive director of Atlanta Birth Center, a nonprofit, freestanding birth center that offers a home-like environment

and family-centered care before, during, and after pregnancy, labor, and birth.

28. Through her midwifery practice and leadership of birth centers, Taitt has focused on building and sustaining community-based maternity care. She has consistently observed that demand for out-of-hospital birth options exceeds available capacity. Families seek these options, but access remains constrained due to a limited workforce.

29. But for Georgia's Midwifery Restrictions, Taitt would practice as a midwife here. She would also be able to hire direct-entry midwives to practice at Atlanta Birth Center.

30. Beyond merely restricting the available workforce, Taitt sees how Georgia's exclusion of direct-entry midwives undermines the sustainability of birth centers, including the one Taitt directs. Birth centers depend on having sufficient trained staff to provide care, but Georgia prevents them from fully using midwives who are specifically trained in out-of-hospital birth. Atlanta Birth Center itself employs direct-entry midwives who, under Georgia regulations, cannot practice to the full extent of their skills and training and instead work as birth assistants. In Taitt's words, "Georgia is squandering a workforce that is ready and available to care for families."

31. **SARAH STOKELY** is a certified nurse-midwife currently licensed in Georgia, North Carolina, and Tennessee. After growing up in Georgia, Stokely obtained her Bachelor of Science in Nursing in South Carolina and her Master of Science in Nurse-Midwifery from Frontier Nursing University in Kentucky. Prior to becoming a nurse-midwife, Stokely worked as a registered nurse, a doula, and a rape crisis and sexual assault nurse examiner in Augusta, Georgia.

32. Stokely was drawn to midwifery in part through the experiences of women in her own family. She recalls her grandmother describing traumatic birth experiences, including being told to "close her legs" and delay pushing during labor because the physician was not ready for the baby to be delivered. Hearing those stories—and realizing how vividly her grandmother

remembered them decades later—left a lasting impression on Stokely about the profound impact of birth care on people's lives.

33. Later, Stokely connected with a direct-entry midwife while working as a doula. She also worked with a physician whose approach was similar to that of midwifery. Observing the time, attention, and respect with which those providers treated patients shaped her decision to pursue midwifery: "I care for my clients as I would have wanted my grandmother, mother, sister, and friend to be cared for. Historically, midwives cared for women through all of life's seasons, meeting them where they are and guiding them through the changes. Midwifery has felt like a vocation and a calling, like my father has demonstrated in his work as a pastor. Like the clergy, midwives are for the people and with the people that they serve."

34. During her nurse-midwifery training, Stokely was taught by both nurse-midwives and direct-entry midwives and sought and gained experience in out-of-hospital births.

35. After graduating, Stokely returned to Georgia, obtained her nursing license, and authorization to practice as a certified nurse-midwife from the Georgia Board of Nursing. For nearly three years, Stokely worked alongside another certified nurse-midwife in a home-birth midwifery practice. The practice paid physicians up to $1,000 per month to enter into a Protocol Agreement with one of the nurse-midwives, but it could not afford to pay twice that amount to cover *both* nurse-midwives. As a result, Stokely was unable to practice to the full extent of her certified nurse-midwife training and licensure and instead limited her work to that of a registered nurse and midwife assistant.

36. Stokely next practiced as a nurse-midwife at birth centers in North and South Carolina.

37. Stokely currently lives in Rome, Georgia, and works as a registered nurse at a

hospital there. She does not, however, practice as a nurse-midwife in Georgia because securing a written Protocol Agreement with a physician is prohibitively expensive. Instead, she travels more than four hours to work as a staff nurse-midwife at an out-of-hospital birth practice in Tennessee that offers a home-like environment. In that setting, her colleagues include licensed direct-entry midwives. At great financial cost, she maintains places to live in Rome as well as in Tennessee, where she stays during the weeks she staffs the Tennessee practice.

38. Families, including in Georgia, seek out Stokely because they want care that respects their autonomy, is more individualized, and treats them as active participants in decisions about their pregnancy and birth. Her patients have often felt rushed, unheard, or constrained in other healthcare settings. They are looking for a provider who will spend time with them, answer their questions, and involve them meaningfully in decisions about their care.

39. But for Georgia's Midwifery Restrictions, Stokely would practice as a certified nurse-midwife here. And but for the prohibition on direct-entry midwife practice, Stokely would work with direct-entry midwives, who she views as experts in home birth.

II. DEFENDANT

40. Defendant is the State of Georgia.

JURISDICTION AND VENUE

41. This action arises under the authority vested in this Court by virtue of O.C.G.A. §§ 9-4-2, 9-4-3, 9-4-9, 9-5-1, and the Georgia Constitution. Venue is proper in this Court under O.C.G.A. § 9-10-30; *see also* O.C.G.A. § 9-4-5, Ga. Const. art. 6, § 2, ¶¶ III, VI.

42. Plaintiffs' claim for declaratory relief is authorized under Article I, Section 2, Paragraph V of the Georgia Constitution. That paragraph waives sovereign immunity "for actions in the superior court seeking declaratory relief from acts of the state . . . in violation of the laws of the Constitution of this state or the Constitution of the United States."

43. Plaintiffs' claim for permanent injunctive relief under O.C.G.A. § 9-5-1 is likewise authorized under Article I, Section 2, Paragraph V of the Georgia Constitution, which waives sovereign immunity for claims for permanent injunctions "after awarding declaratory relief[.]"

STATEMENT OF FACTS

I. PREGNANT PEOPLE IN GEORGIA FACE SEVERE MATERNAL HEALTH CHALLENGES

A. Georgia Ranks Among the Lowest States in Maternal Health Outcomes

44. Georgia has one of the worst maternal mortality rates in the United States—a country that itself has a higher rate of maternal mortality than any other high-income country. According to the Georgia Department of Public Health (DPH), there are 37.9 pregnancy-related deaths per 100,000 live births in the state.[1] DPH has concluded that 87% of those deaths were preventable.[2] More than 80% of these deaths occur postpartum.[3]

45. Maternal mortality is highest among Black Georgians, who are more than twice as likely to die from pregnancy-related causes as white Georgians are.

46. For every maternal death, there are many more people who experience "near misses" and survive serious pregnancy-related complications. Georgia ranks among the worst in the country on severe maternal morbidity (life-threatening maternal complications during delivery hospitalizations).[4]

47. Georgia's infant mortality rate is also among the highest in the nation: there are 7 infant deaths per 1,000 births (compared to 5.6 deaths per 1,000 births in the U.S.).[5] Babies born

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[1] Ga. Dep't Pub. Health, *Maternal Mortality Georgia 2020-2022* (available at https://dph.georgia.gov/maternal-mortality) (last visited Mar. 26, 2026).
[2] *Id.*
[3] *Id.*
[4] America's Health Rankings, *Severe Maternal Morbidity: Georgia*, https://www.americashealthrankings.org/explore/measures/severe_maternal_morbidity/GA (last visited Mar. 26, 2026).
[5] March of Dimes, *2025 March of Dimes Report Card for Georgia* (2025), https://www.marchofdimes.org/peristats/reports/georgia/report-card.

to Black moms have an infant mortality rate 1.5 times higher than the state average.[6] Multiple factors contribute to infant mortality, including access to quality maternal health care.

48. Access to timely prenatal care also remains a challenge in Georgia. Approximately a quarter of pregnant people in Georgia who have a live birth do not receive adequate prenatal care.[7]

49. Georgia has the fourth-highest cesarean delivery rate in the country.[8] Cesarean surgery is a major abdominal operation, typically performed on a conscious patient that carries risks, including infection, hemorrhage, organ injury, and complications during future pregnancies. More than a third of Georgia births are done via cesarean surgeries and a disproportionate share are performed on Black women.[9]

50. Some patients experience severe pain during cesarean surgery, sometimes caused by anesthesia failures, which physicians can often underestimate. Black women are more likely than white women to report experiencing pain during cesarean surgery and to have their concerns minimized, ignored, or dismissed by health care providers.

51. Although cesarean surgeries can be lifesaving in some situations, according to the World Health Organization (WHO), there is no evidence that mortality rates improve when the cesarean rate rises above 10%.[10]

52. Instead, high cesarean delivery rates may reflect provider and hospital preferences and financial incentives. Cesarean surgeries can be scheduled to optimize staffing and be completed quickly. They may be perceived as reducing medical malpractice liability risks and are

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[6] *Id.*
[7] Healthy Mothers, Healthy Babies Coalition of Georgia (HMHBCG), *2025 State of the State: Maternal Health Report March 2025*, at 38 (5th ed. 2025), https://www.hmhbga.org/2025-state-of-the-state-report.
[8] March of Dimes (2025).
[9] *Id.*; Healthy Mothers Healthy Babies Coalition of Georgia (2025).
[10] World Health Organization, *WHO Statement on Cesarean Section Rates*, at 1, 3, 4 (Apr. 14, 2015), https://www.who.int/publications/i/item/WHO-RHR-15.02.

reimbursed at higher rates than vaginal births.

53. Once a patient has a cesarean surgery, future births are far more likely to occur by cesarean. Approximately 90% of people who deliver via cesarean surgery in Georgia will deliver via cesarean in subsequent pregnancies.[11] For the nearly 30% of low-risk women whose first delivery occurs via cesarean section in Georgia, many will be exposed to the added risks that come with repeat cesareans.[12]

54. According to the Centers for Disease Control and Prevention, one in five women reports experiencing mistreatment during maternity care, nearly all of which is provided in hospitals. For Black women in the U.S., the rate is even higher: one in three.[13] Mistreatment of pregnant people—and of Black women in particular—has been documented in Georgia. It can take the form of physical and verbal abuse, delayed and denied care, dismissals of patient concerns, breaches of privacy, and forced or coerced medical interventions.

B. Pregnant People in Georgia Struggle to Find Maternity Care Providers

55. More than half of Georgia counties have insufficient maternity care providers. More than one-third of Georgia counties are considered "maternity care deserts" because they have no obstetric providers, birth centers, or hospitals offering obstetric care.[14] Nearly half of the majority-Black counties in the State fall into this category, compared to less than a third of counties where the majority of residents are white.[15]

56. Georgia has far too few obstetricians. It is well below average in the number of

[11] *See* March of Dimes, *Peristats – Delivery Method: Data for Georgia* https://www.marchofdimes.org/peristats/ (last visited Mar. 26, 2026).
[12] March of Dimes, 2025.
[13] Centers for Disease Control & Prevention, *Respectful Maternity Care* https://www.cdc.gov/vitalsigns/respectful-maternity-care/index.html (updated Sept. 29, 2023).
[14] Jazmin Fontenot, et al., *Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity in Georgia*, March of Dimes (2023), https://www.marchofdimes.org/peristats/reports/georgia/maternity-care-deserts.
[15] Margo Snipe, *Black Women Are Losing Access to Maternity Care. This Law Is Partly to Blame.*, Capital B News (Mar. 9, 2023), https://capitalbnews.org/dangerous-deliveries-maternal-care-deserts/.

obstetricians per 100,000 women of childbearing age, and the rate is worse in rural areas.[16] There is a national shortage of obstetricians, which is expected to worsen over the next decade.

57. Georgia also has far too few midwives. It has approximately 20 certified nurse-midwives for every 100,000 women of childbearing age. Most practice in hospitals and urban areas.[17]

58. Hospital closures have constrained access to maternity care. Many hospitals in Georgia have closed completely or shut down their labor and delivery units. Only one-third of Georgia's rural hospitals still have labor and delivery units.[18] Thirty-four percent of hospitals statewide are at risk of closing, and 15% are at risk of closing in the next two to three years.[19]

59. Georgia residents are far more likely than residents of other states to live more than 30 minutes from a birthing hospital.[20] And women living in Georgia's maternity care deserts travel three times farther for maternity care than those living in areas with full access to providers.[21]

60. Longer travel distances increase the risk of adverse outcomes. Prenatal care for a low-risk pregnancy typically involves a dozen or more in-person visits. For people who must travel long distances to reach a provider, attending these appointments may require taking time off work,

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[16] S.C. Woolcock, et al., *The Supply and Rural–Urban Distribution of the Obstetrical Workforce in Georgia*, Data Brief, WWAMI Rural Health Research Center, Univ. of Wash. (June 2025), https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2025/08/RHRC_DBJUN2025_GA_OB_Woolcock.pdf.

[17] Nicole S. Carlson, *Nurse-Midwives in Georgia: Value for Georgia Citizens*, Testimony Before the Georgia Women's Adequate Health Care Senate Study Comm. (Nov. 18, 2015), https://www.senate.ga.gov/committees/Documents/GeorgiaACNMWomensHealthcareAdequacyCommitteeTestimony118.pdf; Woolcock, *Obstetrical Workforce in Georgia* (2025).

[18] Center for Healthcare Quality & Payment Reform, *Stopping the Loss of Rural Maternity Care* (Mar. 2026), https://chqpr.org/downloads/Rural_Maternity_Care_Crisis.pdf.

[19] Madeline Scheetz, *734 hospitals at risk of closure, by state*, Becker's Hospital Review (Jan. 26, 2026), https://www.beckershospitalreview.com/finance/734-hospitals-at-risk-of-closure-by-state/; Center for Healthcare Quality & Payment Reform, *Rural Hospitals at Risk of Closing* (Jan. 2026), https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

[20] March of Dimes, *Where You Live Matters: Maternity Care in Georgia* (2023), https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Georgia.pdf.

[21] Jazmin Fontenot, et al., *Navigating Geographical Disparities: Access to Obstetric Hospitals in Maternity Care Deserts and Across the United States*, 24 BMC Pregnancy & Childbirth 350 (2024), https://doi.org/10.1186/s12884-024-06535-7.

paying for transportation, and arranging childcare. As a result, some people delay or forgo prenatal care.

61. Health workforce shortages also threaten access to primary care, which helps people enter pregnancy in the best health and reduce the risk of complications. The Human Resources and Services Administration of the U.S. Department of Health & Human Services has designated 233 areas in Georgia as having too few primary care providers to meet residents' needs.[22]

62. In other states, midwives can help bridge this gap, including through work in freestanding birth centers. These centers are distinct from hospitals. They are designed to provide individualized maternal health care for people with low-risk pregnancies in a flexible, home-like environment.

63. Georgia currently has just three licensed birth centers. All are located in the Atlanta metro area.

64. Georgia's birth centers face numerous challenges, including complex administrative processes that enable competing hospitals to block their opening, and difficulty finding midwives trained in out-of-hospital births. Georgia's oldest birth center, which operated in Savannah for nearly 40 years, closed in February 2026.

II. GEORGIA FAMILIES NEED MIDWIVES

65. Georgia families need more skilled maternity care providers, not fewer. Expanding access to midwifery care is widely recognized as a proven strategy for expanding access and improving maternal and infant health outcomes.

A. Physicians and Midwives Serve Different Roles in Maternity Care

66. Maternity care in the United States is provided primarily by two types of

[22] Health Resources & Services Administration (HRSA) Data Warehouse, *Data by Geography*, https://data.hrsa.gov/data/geo (last visited Mar. 5, 2026).

professionals: physicians—most often obstetricians—and midwives.

67. Although their work can overlap, physicians and midwives receive different training, typically have different approaches, and focus on different types of maternity care.

68. Obstetricians are physicians trained to diagnose and treat pregnancy-related complications. Their training focuses heavily on hospital-based care, medical intervention, and surgery. The medical model views pregnancy as a pathological process requiring intensive monitoring and intervention.

69. Midwives specialize in the care of pregnancy and childbirth for people considered low-risk. They provide skilled, compassionate, individualized care during pregnancy, birth, and postpartum. The midwifery model of care approaches birth as a natural, physiologic process rather than a pathology and centers the birthing person's right to make informed, autonomous decisions. Midwives may also provide other sexual and reproductive health care services, such as family planning and preconception care, as well as some newborn care. Depending on their training, some midwives provide primary care from adolescence on.

70. Because most pregnancies are uncomplicated, midwives can safely provide much of the routine care pregnant people need, while physicians play a critical role when complications arise. In Georgia and across most of the U.S., however, most pregnant people will have a hospital-based birth managed by an obstetrician, regardless of individual needs or characteristics.

71. Like other health professionals, midwives collaborate with other providers, including physicians, to provide care together. And, like other health professionals, midwives are trained to identify patients who fit within their scope of practice given risk factors and complications. When more or different care is necessary, midwives consult with or transfer patients to physicians or hospitals.

72. There are risks and costs associated with channeling nearly all low-risk pregnancies into hospitals. People with uncomplicated pregnancies can be harmed by interventions that are not medically indicated, but rather the result of an environment that incentivizes or defaults to them.

B. Midwifery is a Global Profession That Supports Safe Pregnancy and Birth Worldwide

73. Midwifery has deep cultural roots worldwide and midwives have long played a central role in supporting pregnancy and birth within communities.

74. Midwifery is integrated into many health systems across the globe, including in other high-income countries with superior perinatal outcomes.

75. The WHO, in fact, encourages countries worldwide to adopt and maintain midwifery models of care as a cost-effective measure for improving outcomes for pregnant people and newborns while reducing unnecessary medical intervention.

76. According to the International Confederation of Midwives (ICM), midwifery practice includes promoting normal birth, preventive measures, detecting complications, and facilitating access to medical care or other appropriate assistance.[23] A midwife's "scope of practice," or the care that they are deemed competent and permitted to provide, depends on their training, the standards set by their profession, and the laws and regulations of the jurisdiction where they practice.

77. International standards recognize midwifery as an autonomous profession, where midwives determine and control the standards for education, regulation, and practice.[24] In countries that recognize this autonomy, midwives with "full practice authority" are permitted to

[23] Int'l Confederation of Midwives *International Definition & Scope of Practice of the Midwife* (July 23, 2024), https://internationalmidwives.org/resources/international-definition-of-the-midwife/.
[24] Int'l Confederation of Midwives, *Midwifery: An Autonomous Profession*, (June 1, 2023), https://internationalmidwives.org/resources/midwifery-an-autonomous-profession/.

practice to the full extent of their education, training, and competence, and midwifery regulation does not rest with other health professions that may seek to control or restrict the scope of midwifery practice.

C. Direct-Entry Midwives Specialize in Low-Risk Pregnancy and Home and Birth Center Birth

78. In the United States, midwives enter the profession through several different training pathways.

79. Direct-entry midwives are autonomous practitioners who enter the profession directly, rather than through nursing school. Direct-entry midwives include certified professional midwives (CPMs), state-licensed midwives, and traditional midwives. Their training focuses on caring for low-risk pregnancies and supporting births outside hospital settings, particularly in homes or freestanding birth centers.

80. Certified professional midwives complete accredited midwifery education programs or apprenticeship-based training. Regardless of educational path, they must pass a national certification exam.

81. Certified professional midwives provide prenatal care, labor and birth management, postpartum care, and newborn care. They are trained in hands-on techniques used during birth and in non-pharmacological measures that support labor. They are also trained in risk assessment and recognition of complications requiring consultation or referral.

82. The certified professional midwife credential is the only national midwifery credential that requires home birth experience. Certified professional midwives attend the majority of births in homes and freestanding birth centers and represent 9% of the midwifery workforce.[25]

[25] Ellen L. Tilden, et al., *Midwifery Care in the United States: Increasing Access and Utilization to Improve Perinatal Health Outcomes*, 80 Obstetrical and Gynecological Survey 9, 576 (2025), https://doi.org/10.1097/OGX.0000000000001427.

83. Thirty-seven states license certified professional midwives, including the surrounding states of Alabama, Arkansas, Florida, Kentucky, Louisiana, South Carolina, and Tennessee.[26] In several additional states, at least some direct-entry midwives are permitted to practice or there is no prohibition on their practice.

84. State-licensed midwives are those who have met state licensure requirements that are very similar to, or overlapping with, those for certified professional midwives, but do not require the midwife to obtain the certified professional midwife credential. State-licensed midwives are often referred to as "licensed midwives."

85. Traditional midwives typically train through apprenticeship with more experienced midwives, who pass midwifery skills—as well as cultural traditions related to pregnancy and birth—from one generation to the next. Traditional midwives typically do not hold formal credentials and instead rely on recognition rooted in their community's practices.

D. Certified Nurse-Midwives Are Autonomous, Advanced Practice Providers of Maternity Care

86. Another pathway into midwifery is through nursing. Certified nurse-midwives (CNMs) are registered nurses who complete graduate-level midwifery education and pass a national certification exam.

87. Certified nurse-midwives provide prenatal, birth, postpartum, and newborn care, as well as preconception, sexual, reproductive, and gynecologic care. Their practice includes diagnosing and treating conditions, prescribing medications, ordering and interpreting diagnostic tests, and managing patient care. They are also trained to assess risk throughout pregnancy and

[26] Nat'l Ass'n of Certified Professional Midwives (NACPM), *Which States Recognize CPMs?*, https://www.nacpm.org/state-recognition-of-cpms (last visited Mar. 26, 2026); NACPM, *What CPM Educational Pathways Lead to Licensure in Each State?*, https://www.nacpm.org/what-cpm-pathways-are-honored-by-each-state (last visited Mar. 26, 2026).

childbirth and to consult with or refer individuals to physicians or hospitals when complications arise or care needs exceed their scope of practice.

88. Certified nurse-midwives practice primarily in hospital settings but may also train—typically after they graduate—to attend births in homes or birth centers.

89. Certified nurse-midwives are typically regulated alongside other advanced practice registered nurses (APRNs), such as nurse practitioners.

90. All 50 states license certified nurse-midwives. Most states grant them full practice authority. A minority of states, including Georgia, however, require certified nurse-midwives to have a written agreement with a physician to practice.[27]

91. Certified midwives (CMs) have the same scope of practice as certified nurse-midwives but do not attend nursing school. Despite their similarities with certified nurse-midwives, many fewer states recognize or license them. Georgia is not among them.

92. Certified nurse-midwives and certified midwives provide more than 90% of midwifery care in the U.S. and attend around 10% of all births nationwide.[28]

E. Midwives Provide Safe and Effective Maternal Healthcare

93. Extensive research demonstrates that midwifery-led care improves outcomes while reducing unnecessary intervention and cost.

94. Studies consistently show that people who receive midwifery care are less likely to undergo unnecessary cesarean surgeries, episiotomies, epidurals, or drug-induced labor—interventions that can lead to complications. They are also more likely to breastfeed and to report positive and joyful birth experiences. Nationwide research finds that births attended by certified

[27] Nat'l Conf. of State Legislatures (NCSL), *Certified Nurse Midwife Practice and Prescriptive Authority*, (Feb. 2025), https://www.ncsl.org/scope-of-practice-policy/practitioners/advanced-practice-registered-nurses/certified-nurse-midwife-practice-and-prescriptive-authority.

[28] American College of Nurse-Midwives, *Essential Facts about Midwives: Midwives and Birth in the United States*, https://midwife.org/wp-content/uploads/2024/10/Essential-Facts-about-Midwives.pdf (last visited March. 26, 2026).

nurse-midwives are associated with lower infant and neonatal mortality and fewer low-birthweight babies. Research focusing on low-income patients also finds that those receiving midwifery care in birth centers have better infant outcomes—lower rates of preterm birth and fewer low-birthweight babies—than comparable patients.

95. These benefits are strongest when midwives—both direct-entry and nurse-midwives—are integrated into the health care system in ways that facilitate collaboration and care coordination. Indicators of low integration include prohibitions on direct-entry midwives, mandatory physician supervision and collaborative agreement requirements, and limitations on scope of practice. Given racial disparities in maternal and infant health, greater integration of midwives is particularly important for Black mothers and the survival of their babies.

96. Midwifery care can also reduce the cost of obstetric services because low-risk pregnancies managed by midwives typically require less physician time, fewer medical interventions, shorter hospital stays, and fewer associated hospital resources.

F. Georgia Families Seek Out Midwifery Care for Personal, Health, and Cultural Reasons

97. Pregnant people seek midwifery care and choose to birth at home or in a birth center for different reasons.

98. Some wish to avoid unnecessary medical interventions. Others seek providers and care settings that they most trust to honor their health care decisions. Individuals who have had traumatic birth experiences in a hospital or encounter rigid protocols that limit their autonomy—such as restrictions on movement, food, or drink during labor, visitors and support people, or contact with their newborn—may seek alternatives.

99. Many families value the continuity of care midwives provide—receiving care from the same provider across prenatal visits, labor and delivery, and the postpartum period, including

home visits that allow individuals and families to receive care without the burden of traveling with a newborn.

100. Midwifery care can also enable individuals who want to safely practice cultural, spiritual, or religious traditions related to labor and birth, such as giving birth on land with personal, ancestral, or historical significance or incorporating family members.

101. Because midwives may provide care in homes, freestanding birth centers, and hospitals, communities with midwives practicing in each setting offer residents meaningful options about where and how to birth.

102. Black women in Georgia are among those calling for midwifery and out-of-hospital birth options, in part to reduce exposure to obstetric mistreatment and racism reported in hospital settings.

103. Excessive restrictions on midwives undermine individual choice and make it more difficult for midwives to practice in communities that want and need them.

III. GEORGIA LAW IMPOSES DRACONIAN LIMITS ON MIDWIFERY

A. Georgia Bars Direct-Entry Midwives from Practicing

104. Georgia's Midwifery Statute establishes that "[n]o person shall practice midwifery without first receiving from the Department of Public Health a certificate of authority" and registering with the county board of health and local registrar. O.C.G.A. § 31-26-2(a).

105. The Statute says DPH[29] and designated county boards of health "shall" issue, refuse to issue, suspend, or revoke certificates of authority. *Id.* § 31-26-2(d). To obtain a certificate of authority, an applicant must complete courses prescribed by DPH, pass a DPH-administered exam, and either undergo a physical examination or provide evidence of personal health as requested by

[29] DPH was created through a reorganization of the Department of Human Resources ("DHR"). For ease of reference, this Complaint refers to the agency authorized to regulate midwives as DPH.

DPH. *Id*. § 31-26-2(c).

106. The statute also authorizes DPH to adopt rules setting out the "minimum educational and physical requirements for midwives and procedures and techniques to be employed and ethics to be observed in the practice of midwifery." *Id.* § 31-26-3.

107. Beyond stating that applicants "shall be of good character and sound mind, shall be free of tuberculosis, sexually transmitted diseases, and other communicable diseases in the infectious stage, and shall be protected against smallpox," *id*. § 31-26-2(b), Georgia law provides no specifics about the type of education, physical requirements, procedures, or techniques to guide DPH in determining eligibility for a midwifery certificate.

108. A certificate of authority permits midwives to attend only "normal childbirth," which means the "delivery, at or close to term, of a pregnant woman whose physical examination *by a physician* reveals no abnormalities and who does not have signs or symptoms of hemorrhage, toxemia, infection, abnormal position or presentation, or prolonged labor." *Id.* §§ 31-26-5, -1(2) (emphasis added).

109. In Georgia, midwives may not "perform any internal examinations or manipulations of any kind." *Id.* § 31-26-5. If a newborn "is not delivered spontaneously within a reasonable time," the midwife must notify a physician "immediately" and may not make any "effort to deliver the child except under direction and supervision of such physician." *Id.*

110. By regulation, DPH defines "midwifery" as "any act or practice of attending women in childbirth, whether or not for consideration" and the "independent management of care of newborns, and the antepartal, intrapartal, or postpartal care of women." Ga. Comp. R. & Regs. 511-5-1-.01(2).

111. In 2015, DPH issued rules providing that "[n]o person shall practice midwifery, or

hold himself or herself out to the public as a midwife, unless that person has a current certification from the Georgia Board of Nursing to practice as a Certified Nurse-Midwife." Ga. Comp. R. & Regs. 511-5-1-.02 (citing Ga. Comp. R. & Regs. 410-11-02, "Rules for Certified Nurse Midwives").[30] Certification as a nurse-midwife "constitute[s] the certification required under Code Section 31-26-2, and no additional certification from the Department of Public Health or from a County Board of Health shall be required." Ga. Comp. R. & Regs. 511-5-1-.02.

112. As a result, regardless of their training, experience, or skills, only midwives who are certified by the Board of Nursing as nurse-midwives may practice midwifery here.

B. Georgia Subjects Certified Nurse-Midwife Practice to Physician Control

113. Four sets of statutes and administrative rules govern certified nurse-midwife practice: (1) the Nurse Practice Act, which regulates advanced practice registered nurses, including certified nurse-midwives, O.C.G.A. §§ 43-26-1 through 43-26-13; (2) Board of Nursing regulation, including rules specific to certified nurse-midwives and rules related to Protocol Agreements, Ga. Comp. R. & Regs. 410-11; (3) the Medical Practice Act's Protocol Agreement Requirements under O.C.G.A. § 43-34-23 and § 43-34-25; and (4) Georgia Composite Medical Board (GCMB) rules for Protocol Agreements under § 43-34-25, Ga. Comp. R. & Regs. 360-32-.01–.07. The statutes and administrative rules relating to Protocol Agreements are referred to collectively as the "Protocol Agreement Requirements."

114. Georgia defines certified nurse-midwife scope of practice as the "independent management of women's health care, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women." Ga. Comp. R. & Regs. 410-11-.02(2)(a). A certified nurse-midwife "practices within a

[30] DPH mis-cites the Board of Nursing's rules for certified nurse-midwives. The correct citation is Ga. Comp. R. & Regs. r. 410-11-.02, not Ga. Comp. R. & Regs. 410-12-.02, which instead relates to incident reporting.

health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client" and consistent with the Standards of Practice of the American College of Nurse-Midwives. *Id*. Certified nurse-midwives are the only advanced practice registered nurses whose practice Georgia law defines as collaborative and "independent." *Compare, e.g.*, *id.* 410-11-.02(2)(a) *with id.* 410-11-.03(2) (describing the nurse practitioner scope of practice).

115. Advanced practice registered nurses, including certified nurse-midwives, do not, however, have full practice authority in Georgia. The Medical Practice Act subjects their practice to physician control through mandatory, written Protocol Agreements with physicians.

116. But for the Protocol Agreement Requirements, Georgia's certified nurse-midwives could perform all acts within their scope of practice autonomously; only the Protocol Agreement Requirements prevent them from doing so. *See* O.C.G.A. § 43-26-3(1) (defining advanced nursing practice); *id.* § 43-26-3(1.1) (defining APRN); Ga. Comp. R. & Regs. 410-11-.01 (defining advanced nursing practice); *id.* 410-11-.02 (defining certified nurse-midwife practice).

117. The Medical Practice Act includes two Protocol Agreement schemes under which a certified nurse-midwife may practice.

118. The first governs physicians who delegate to advanced practice registered nurses the authority to perform certain "medical acts," including but not limited to "administering and ordering [] any drug" and "order[ing] controlled substances, dangerous drugs, medical treatments, and diagnostic studies." O.C.G.A. § 43-34-23(a)(7). Here, "order" means "to select a drug, medical treatment, or diagnostic study" but not prescribe them. *Id.* § 43-34-23(a)(8), (b)(1)(A)–(B). "Drugs" includes prescription medications and controlled substances other than those in Schedule I. *Id.* § 43-34-23(a)(2), (5).

119. The first Protocol Agreement Statute states that it does not limit nursing practice as authorized by the Nurse Practice Act. *Id.* § 43-34-23(e).

120. By statute, the only qualification for a delegating physician under § 43-34-23 is a Georgia medical license. *Id.* § 43-34-23(a)(7).

121. The Nurse Practice Act references Protocol Agreements under § 43-34-23 only with respect to registered nurses—not advanced practice registered nurses. O.C.G.A. § 43-26-5(a)(12) (authorizing the Board of Nursing to enact rules "for registered professional nurses in their performing acts under a nurse protocol as authorized in Code Section 43-34-23").

122. Board of Nursing rules add that Protocol Agreements must "provide[] for immediate consultation with the delegating physician or a physician designated in the absence of the delegating physician" and must "include provisions for periodic review of patient records." Ga. Comp. Rules & Reg. 410-11-.13(2)(c), (3)(c).

123. The second Protocol Agreement Statute authorizes physicians to delegate to advanced practice registered nurses "certain medical acts," including but not limited to "ordering of drugs, medical devices, medical treatments, diagnostic studies, or radiographic imaging tests." O.C.G.A. § 43-34-25(a)(10). Here, "order" means "to prescribe pursuant to a nurse protocol agreement." *Id.* § 43-34-25(a)(11), (b). "Drugs" means both prescription medications and controlled substances in Schedules III to V. *Id.* § 43-34-25(a)(3), (7). The terms "medical acts," "medical devices," and "medical treatments" are not defined.

124. The second Protocol Agreement Statute states that it does not require an advanced practice registered nurse to enter into a Protocol Agreement to practice as a registered professional nurse or an advanced practice registered nurse. *Id.* § 43-34-25(j).

125. By statute, a Protocol Agreement under O.C.G.A. § 43-34-25 must:

a. be with a Georgia-licensed physician "in a comparable specialty area or field," *id.* § 43-34-25(c)(1), whose principal place of practice is in the state or, if it is out of state, within 50 miles of where the certified nurse-midwife practices. *Id.* § 43-34-25(a)(12);

b. contain "a provision for immediate consultation," *Id.* § 43-34-25(c)(2);

c. "[i]dentify the parameters under which delegated acts may be performed," including the number of refills of prescription medications, the kinds of diagnostic studies, and the extent to which radiographic imaging tests may be ordered, and the circumstances under which a prescription may be executed. *Id.* § 43-34-25(c)(3);

d. provide that X-rays, ultrasounds, or radiographic imaging tests "shall be read and interpreted by a physician." *Id.* § 43-34-25(c)(3);

e. "[i]nclude a schedule for periodic review by the delegating physician of patient records," which may be completed with a sampling of records determined by the delegating physician. *Id.*§ 43-34-25(c)(5); and

f. provide that the delegating physician will evaluate at least quarterly every patient to whom a certified nurse-midwife prescribes a prescription drug or controlled substance. *Id.* § 43-34-25(c)(9).

126. A physician may not enter into a Protocol Agreement under § 43-34-25 with more than eight advanced practice registered nurses or physician assistants at a time. *Id.* § 43-34-25(g). That limit, however, does not apply to advanced practice registered nurses practicing in certain settings, such as hospitals, birthing centers, or in State or county health departments. *Id.*

127. Both the Board of Nursing and the Georgia Composite Medical Board regulate Protocol Agreements under § 43-34-25.

128. The Board of Nursing rules closely mirror the Medical Practice Act's requirements. Ga. Comp. Rules & Reg. 410-11-.14.

129. The Georgia Composite Medical Board rules require the delegating physician to:

a. be "available for direct communication or by telephone" or other means, Ga. Comp. R. & Regs. 360-32-.01(8);

b. "document and maintain a record of direct onsite observation of the [certified nurse-midwife] practice" and review medical records on a quarterly basis, Ga.

Comp. R. & Regs. 360-32-.05(2); and

c. ensure medical acts performed by the certified nurse-midwife are consistent with their "education, training, experience, and competence," and within the certified nurse-midwife's "scope of practice, specialty area or field and certification." Ga. Comp. R. & Regs. 360-32-.05(3)(a)–(b).

130. Protocol Agreements under O.C.G.A. § 43-34-25 are subject to review and approval by the Georgia Composite Medical Board, which has 15 members, 13 of whom are physicians. O.C.G.A. § 43-34-2.

C. Violation of the Midwifery, Nursing, or Medical Practice Laws Is a Civil Offense and a Crime

131. Violation of the Georgia midwifery or nursing laws carries civil penalties and/or can constitute a misdemeanor, which carries a $1,000 fine, 1 year of imprisonment, or both. O.C.G.A. §§ 31-26-6 and -7, 31-5-9(a) (DPH and county boards of health may seek injunctions against violators); *id.* § 31-5-8 (misdemeanor penalty for violation of much of title 31, including chapter 26); *id.* § 43-26-10 (practicing nursing without a license is a misdemeanor); *id.* § 43-26-5; Ga. Comp. R. & Regs. 410-11-.09 (penalties for unauthorized practice of nursing); O.C.G.A. § 17-10-3 (misdemeanor penalties).

132. "Any person who practices medicine" in violation of the Medical Practice Act faces felony penalties of two to five years imprisonment, a $1,000 fine per violation, or both. O.C.G.A. § 43-34-42(a). An act performed pursuant to a physician-authorized Protocol Agreement is *not* considered the practice of medicine. *See id.* § 43-34-23(d).

IV. GEORGIA HAS ENGAGED IN A HISTORIC CAMPAIGN TO MARGINALIZE AND ULTIMATELY ELIMINATE MIDWIVES

133. The Midwifery Restrictions that exist today continue a historical pattern of restricting midwifery practice.

134. Before Georgia began regulating midwifery, midwives were the primary providers of maternity care in the State. Thousands of midwives—estimates range from 5,000 to 9,000—attended most births.[31] Most midwives were Black women who served both white and enslaved, and later emancipated, Black families. Through apprenticeships, these midwives carried forward both knowledge of childbirth and African traditional and community practices. They often worked under conditions of profound poverty, racial segregation, and geographic isolation, at a time when physicians and hospitals were scarce or inaccessible to many families.

135. Georgia began formally regulating midwives in 1925, at the recommendation of the Medical Association of Georgia (MAG), which urged midwife instruction "under the supervision and direction of some physician who is a member of this Association, in each county."[32] The Board of Health adopted this recommendation.

136. Georgia required midwives to be certified, attend classes taught by public health nurses and physicians, pass an examination, report births, and comply with state rules governing midwifery practice. Instruction emphasized hygiene, asepsis, and preparation for childbirth, which many midwives sought to incorporate into their practices, even as widespread poverty and limited resources made this more difficult. Midwives were also required to obtain a physician-issued permission slip before accepting an individual under their care, placing physicians in a gatekeeping role over midwifery practice.

137. Georgia officials treated midwives as a "problem" at that time. The Director of the Division of Child Hygiene claimed that "practically all midwives are negroes who have reached

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[31] Joe P. Bowdoin, *The Midwife Problem*, 91 JAMA 7, 461 (1928) (Georgia believed there were 5,000 midwives practicing in 1924), https://jamanetwork.com/journals/jama/article-abstract/259012 [Bowdoin, *Midwife Problem*]; Ga. Dep't Pub. Health, Ann. Rep. of the Director, at 15 (1936) (stating in 1925, there were "around 9,000 midwives practicing in Georgia").

[32] Judy Barrett Litoff, American Midwives 1860 to the Present, at 104 (1978) (quoting May 9, 1924, MAG resolution); *see also* Bowdoin, Midwife Problem, at 460–61.

middle age or over," and asserted that they "are, as a rule, ignorant and superstitious, having absorbed many things from the traditions of the race."[33] Regulation was not for safety: it was a gradual process of "elimination" of the "old, the unclean and the unfit."[34] The State urged local physicians to "assist in this weeding out"[35]—a directive that explicitly enlisted physicians in the effort to remove midwives from practice.

138. Rather than integrating midwives into the health system, the regulatory efforts largely treated them as an inferior and temporary solution—using midwives to provide care until physicians and hospitals could replace them.

139. In 1927, midwives delivered nearly a third of all births in Georgia, mostly in Black and rural communities facing physician shortages.[36] At the time, only approximately 2,000 physicians served 161 counties. Many counties had no physicians at all.[37]

140. By 1941—approximately 15 years after state regulation began—the number of certified midwives had fallen to about 2,500, reducing the midwifery workforce by at least half.[38] State officials understood the consequences: their actions "foreshadow[ed] the disappearance of midwives from many communities."[39] Some communities were left without "a sufficient number to meet current demands," and "several communities are without any midwives."[40]

141. As Georgia dismantled access to midwifery care, officials acknowledged that it was "imperative that some other type of intrapartum care" replace it.[41] They hoped the absence of midwives would lead to the development of physician-managed hospital births. But physicians

[33] Bowdoin, Midwife Problem, at 460.
[34] *Id.*
[35] *Id.* at 461
[36] *Id.*
[37] *Id.* at 460
[38] Ga. Dep't of Pub. Health, Ann. Rep. for the Year 1941, at 54 (1942).
[39] Ga. Dep't of Pub. Health, Ann. Rep. for the Year 1943, at 131 (1944).
[40] *Id.*
[41] *Id.*

and hospitals did not automatically replace the care midwives had long provided. Hospital care remained geographically inaccessible, financially out of reach for many, and often unavailable to Black people due to segregation and discrimination.

142. Although the campaign to regulate midwives was framed as a response to poor maternal and infant health outcomes, evidence available at the time did not support the claim that midwives were responsible for those outcomes. Investigations concluded that mortality was frequently associated with infection, excessive obstetric intervention, and poor hospital practices—rather than midwifery care. Meaningful improvements in maternal and infant health began only later, following the introduction of antibiotics, improved infection control, and other broader public health advances.

143. It was in this context, in 1955, that Georgia enacted the Midwifery Statute, which remains in effect today. It directs DPH to establish educational requirements and standards governing midwifery practice, and to issue certificates to midwives permitting them to practice. O.C.G.A. § 31-26-1, *et seq*.

144. Within a decade, DPH largely stopped certifying new midwives, effectively phasing out the existing workforce. In 1963, it declared hospital delivery "the ultimate desirable goal," stated that "the training and licensure of new midwives is not recommended," and allowed certification only in "[e]xtenuating" circumstances."[42]

145. In 1979, DPH declared that "no new lay-midwives be certified."[43]

146. In 1990, DPH informed direct-entry midwives seeking certification that it "no longer issue[s] certificates for lay midwifery."[44] Instead, "the only midwives who are certified are

[42] Ga. Dep't of Pub. Health Mem. to All Local Health Dep'ts, Policy on Training New Midwives (May 6, 1963).
[43] Ga. Dep't of Pub. Health Mem. to Council on Maternal and Infant Health (Aug. 17, 1979).
[44] *E.g.*, Ga. Dep't of Human Resources to Deborah Ann Pulley (Mar. 21, 1990).

graduates of nurse midwifery schools who are nationally certified and are recognized by the Georgia Board of Nursing."[45] Local officials increasingly sought injunctions against direct-entry midwives for practicing without a certificate.

147. The following year, DPH acknowledged that it was failing to fulfill its statutory duty to certify midwives. Rather than fulfill that duty by restoring the pathway created by the Statute, though, DPH adopted emergency rules redefining "midwife" to mean only certified nurse-midwives. The agency had effectively replaced the General Assembly's broader midwifery regulatory scheme with one limited to nurse-midwives.

148. In 2015, DPH again revised its rules to declare that "[n]o person shall practice midwifery, or hold himself or herself out to the public as a midwife, unless that person has a current certification from the Georgia Board of Nursing to practice as a Certified Nurse-Midwife." Ga. Comp. R. & Regs. 511-5-1-.02.

149. DPH's actions eliminated the certification pathway established by the Midwifery Statute and abdicated its responsibility to set requirements for midwives and issue certificates authorizing midwifery practice.

150. DPH's action was contrary to law. Recall that the General Assembly had created two distinct regulatory schemes: certified nurse-midwives, regulated by the Board of Nursing under the Nurse Practice Act, and other midwives, regulated by DPH under the Midwifery Statute.

151. Despite this statutory scheme, DPH granted the Board of Nursing sweeping authority to determine who may practice midwifery and the power to enforce violations of midwifery laws as violations of nurse-midwifery laws. *See* Ga. Comp. Rules & Reg. 511-5-1-.02.

[45] *Id.*

152. The Board of Nursing has relied on this authority to issue cease-and-desist orders against direct-entry midwives. In 2019, the Board sent a cease-and-desist order to a certified professional midwife, demanding she stop identifying herself as a midwife. The dispute resulted in litigation that concluded in 2020 with a consent order under which the Board of Nursing agreed it would not pursue cease-and-desist actions against individuals who use the term "midwife" if they do not represent that they may lawfully provide midwifery services in Georgia and are not engaged in the unlicensed practice of "nursing (midwifery)." Consent Order & Final Judgment, *Pulley v. Thompson*, No. 1:19-cv-05574-AT (N.D. Ga. July 8, 2020).

153. The Board continues to send cease-and-desist orders asserting that direct-entry midwives unlawfully hold themselves out as certified nurse-midwives. Because DPH recognizes only certified nurse-midwives as "midwives," and the Board of Nursing treats midwifery practice by anyone else as the unlicensed practice of nursing, direct-entry midwives are ensnared in a regulatory trap.

154. Midwives, families, and maternal health advocates have sought to restore a legal pathway for direct-entry midwives to practice through DPH or legislation. As they can wait no longer, Plaintiffs now turn to the judiciary for relief.

V. GEORGIA SUBORDINATED CERTIFIED NURSE-MIDWIFE PRACTICE TO PHYSICIAN CONTROL

155. As Georgia dismantled reliance on traditional, community-based Black midwives, it positioned nurse-midwives as a professional alternative aligned with physicians and hospitals. Constraining midwifery practice to physician oversight and control, however, is unnecessary to achieve public health and further marginalizes midwifery.

156. As public health programs expanded in the early twentieth century, the white public health nurses who supervised and trained Black midwives became the foundation of nurse-

midwifery in Georgia. Some of these nurses began receiving midwifery training and providing maternity care themselves, particularly through pilot programs associated with hospitals and public health departments.

157. Physicians initially did not view these nurse-midwives as competitors. Writing to the Medical Association of Georgia in 1950, for example, a physician involved in one pilot project reassured the organization that nurse-midwives were "not in competition with doctors;" instead, any competition was "with lay midwives."[46]

158. Although Georgia's certified nurse-midwives had advanced clinical training and expertise, their practice remained subordinate to physicians. Certified nurse-midwives' authority to provide care derived from physician delegation or hospital policies. They primarily practiced in physician-led maternity care systems.

159. As nurse-midwifery expanded and certified nurse-midwives began providing care to a broader range of patients, physicians increasingly viewed them as competitors rather than as providers filling gaps in care. Physicians blocked certified nurse-midwives' access to hospital privileges, restricted the types of insurance they could accept, and declined to collaborate, consult, or provide emergency transfer services.

160. Federal antitrust authorities investigated these actions. The Federal Trade Commission brought enforcement actions against hospital medical staff in Savannah for conspiring to deny hospital privileges to certified nurse-midwives without legitimate patient-care justifications. *Matter of Med. Staff of Mem'l Med. Ctr.*, 110 F.T.C. 541 (1988). The FTC concluded these actions suppressed competition in the provision of maternity services. *Id.* It entered orders

[46] Helen Varney Burst & Joyce E. Thompson, A History of Nurse-Midwifery in the United States: The Midwife Said Fear Not, at 95 (2015).

prohibiting agreements among physicians to restrict certified nurse-midwives' hospital privileges without a reasonable basis. *Id.*

161. Similar allegations arose elsewhere. In Athens, a certified nurse-midwife alleged that local obstetricians and hospitals conspired to exclude her from the maternity care market by restricting her access to patients and discouraging physicians from providing backup services. *See Sweeney v. Athens Reg'l Med. Ctr.*, 709 F. Supp. 1563 (M.D. Ga. 1989) (denying summary judgment to physicians on federal antitrust, state tort, and state deceptive trade practices claims); *Sweeney v. Athens Reg'l Med. Ctr.*, 917 F.2d 1560 (11th Cir. 1990) (stating that the case settled).

162. When Georgia enacted statutes addressing nurse-midwifery in 1989, it recognized certified nurse-midwives but structured their practice under physician control. The first statute, O.C.G.A. § 43-34-23, authorized physicians to delegate certain medical acts to advanced practice registered nurses, including certified nurse-midwives, pursuant to written Protocol Agreements.

163. In 2006, Georgia enacted O.C.G.A. § 43-34-25, granting physicians the authority to delegate prescriptive authority to advanced practice registered nurses. To enact that statute, advanced practice registered nurses had to agree that both the Georgia Composite Medical Board and Board of Nursing would have regulatory authority. Georgia was the last state in the nation to grant prescriptive authority to advanced practice registered nurses, even in this restricted form.

164. The Board of Nursing has enforced the Protocol Agreement Requirements by taking disciplinary action against certified nurse-midwives who fail to comply. Until recently, certified nurse-midwives risked not only losing authorization to practice as midwives but also their licensure as registered nurses. *See* O.C.G.A. § 43-26-7.1 (as of September 1, 2025, providing for separate licensure for advanced practice nurses rather than authorization for registered nurses to practice as advanced practice registered nurses).

165. Physician organizations in Georgia have actively opposed efforts to allow certified nurse-midwives to practice independently.

VI. GEORGIA'S MIDWIFERY RESTRICTIONS SUPPRESS MIDWIVES AND REDUCE ACCESS TO MATERNITY CARE

166. Georgia's Midwifery Restrictions suppress midwifery practice without improving outcomes. Excluding direct-entry midwives from practice and conditioning certified nurse-midwives' practice on physician permission burdens midwives' right to practice their chosen profession, places physicians—midwives' direct marketplace competitors—in control of whether midwives may enter and remain in the field, reduces the availability of maternity care providers, restricts the development of birth centers and home birth practices, and leaves many pregnant people without meaningful access to midwifery care.

A. Georgia's Midwifery Restrictions Burden Midwives' Right to Practice Their Chosen Profession

167. At a time when families struggle to find prenatal, labor, and postpartum care, Georgia has chosen to restrict midwifery practice to certified nurse-midwives only and further restricts those midwives by subjecting their practice to physician control.

1. Direct Entry Midwives

168. Georgia law criminalizes the practice of direct-entry midwives. *See* O.C.G.A. § 31-5-8 (misdemeanor penalty for violation of much of title 31, including chapter 26, where the Midwifery Statute is located). As a result, some direct-entry midwives do not practice their chosen profession in Georgia at all. Others restrict their practice to that of birth assistants or find other work, despite their significant midwifery training and experience.

169. Even if permitted to practice, Georgia law bars direct-entry midwives from caring for an individual unless a physician—based on a physical exam—verifies the individual's birth

will be "normal," giving physicians control over midwives' practice and preventing them from independently evaluating, accepting, or caring for patients based on their training and experience.

170. Georgia law further prohibits midwives from "perform[ing] any internal examinations or manipulations of any kind," and, if a newborn is not delivered "within a reasonable time," requires them to notify a physician "immediately" and bars them from making any "effort to deliver [a] child except under direction and supervision of such physician." *Id.* § 31-26-5. These restrictions eliminate core aspects of midwifery care—assessment of labor progress, clinical decision-making, and hands-on monitoring and assistance during labor and delivery—making autonomous practice effectively impossible.

2. Certified Nurse-Midwives

171. Although Georgia law permits certified nurse-midwives to practice, the Protocol Agreement Requirements burden—and in some cases prevent—certified nurse-midwives from practicing their chosen profession.

172. Locating a physician willing to enter a formal, written Protocol Agreement is itself an obstacle. Physicians have no obligation to enter into such agreements. Concerns about malpractice liability, compliance with state law, or the demands of their own practices may disincentivize them. The State maintains no centralized mechanism to connect certified nurse-midwives with physicians, forcing them to market themselves to physicians in unequal negotiations.

173. Certified nurse-midwives cannot employ physicians whose contracts they are required to obtain, leaving nurse-midwives dependent on physicians willing to enter into such contracts outside of such an employment relationship. *See* Ga. Comp. R. & Regs. 360-32-.04(5).

174. The pool of physicians with whom certified nurse-midwives may enter into a Protocol Agreement is limited. Georgia has a severe shortage of obstetricians: in 2024, the State

had 1,200 OB-GYNs[47] and over 600 certified nurse-midwives.[48] Some physicians' disapproval of out-of-hospital birth further constrains this pool, making it especially hard for midwives who attend home births or practice at birth centers to find physicians willing to enter into a Protocol Agreement.

175. Even when a physician is willing to contract, certified nurse-midwives often must pay physicians substantial monthly fees—ranging from hundreds of dollars to over $1,000—to maintain the agreement. Some certified nurse-midwives pay private companies to broker relationships with physicians and manage these agreements, adding an additional layer of cost.

176. The physician retains the power to terminate the Protocol Agreement at any time and cut off a certified nurse-midwife's ability to practice.

177. As a result, some certified nurse-midwives do not practice in Georgia at all and instead seek employment out of state. Others restrict their practice to that of a registered nurse or midwife assistant, to their financial detriment, despite their advanced midwifery training.

3. No Demonstrated Safety Justification

178. The Midwifery Restrictions lack a demonstrated connection to health and safety. Instead, they rest on unsupported assumptions that only certified nurse-midwives are qualified to practice midwifery and that physician oversight is necessary to ensure safe midwifery care.

179. Evidence from other states proves these assumptions wrong. Elsewhere, certified nurse-midwives practice with greater autonomy, direct-entry midwives are permitted to practice, and maternal and neonatal outcomes are comparable to or better than those in Georgia.

180. The Midwifery Restrictions also fail to reflect differences in training and scope of

[47] *State of Georgia Health Care Workforce*, Georgia Data Analytics Center, https://gdac.georgia.gov/health-0 (last visited Mar. 26, 2026).
[48] *Certified Nurse-Midwives/Certified Midwives by State*, American Midwifery Certification Board (May 2024), https://www.amcbmidwife.org/docs/default-source/default-document-library/number-of-cnm-cm-by-state---may-2024.pdf?sfvrsn=c9c33547_0.

practice between physicians and midwives. Obstetric training focuses primarily on hospital-based births, medical and surgical intervention, and the management of complicated pregnancies. Midwifery training, by contrast, focuses on supporting physiologic birth and caring for low-risk people, including in out-of-hospital settings.

181. Most pregnancies are "low risk." For those pregnancies, midwives are specifically trained to support normal labor and birth while monitoring for complications and referring patients to physicians when higher-risk care becomes necessary. Georgia law nonetheless permits physicians to attend low-risk births independently in homes, birth centers, or hospitals, while barring or restricting midwives—whose training focuses specifically on those births—from providing the same care.

182. Georgia law likewise disregards direct-entry midwives' expertise in out-of-hospital birth. Neither physicians nor nurse-midwives are required to have training or experience in out-of-hospital birth. Yet, Georgia permits them to practice in those settings while barring all direct-entry midwives—who are specifically trained in out-of-hospital birth—from practicing at all.

183. Like other health professionals, midwives are trained both to assess whether prospective patients fall within their scope of practice and to recognize and respond to complications that may arise during care. That training includes screening for risk factors, identifying when a pregnancy is no longer "low risk," and consulting with or transferring care to other providers or settings when a patient's needs exceed the midwife's scope.

184. The Midwifery Restrictions nonetheless assume—without evidence—that physician involvement is necessary for safe care.

185. For direct-entry midwives, requiring a physician to verify that a patient will experience a "normal childbirth" adds no meaningful protection beyond the assessment midwives

already perform. Other provisions purporting to require physician involvement in labor and delivery prohibit midwives from engaging in basic clinical functions absent physician direction and supervision, and mandate immediate physician notification in certain circumstances. These requirements do not produce meaningful collaboration and instead prioritize notifying a physician over measures that may be more effective. For example, appropriate care may involve contacting emergency services or arranging a transfer to a hospital—not attempting to locate or report to a physician.

186. For certified nurse-midwives, physician oversight under the Protocol Agreement Requirements is largely retrospective. Physicians periodically review records and occasionally observe practice, but are not required to be present during care, provide real-time collaboration, or accept transferred patients.

187. Research demonstrates that when certified nurse-midwives are permitted to practice to the full extent of their training, maternal and infant outcomes improve and access to care expands. There are lower rates of medical intervention, complications, and preterm birth, and higher odds of vaginal birth, vaginal birth after cesarean (VBAC), and breastfeeding.

188. States that grant full practice authority have more practicing midwives and greater access to maternity care providers, while states requiring physician involvement have fewer providers and larger access gaps. Removing physician-oversight requirements also reduces geographic disparities by increasing provider availability in rural and underserved communities.

189. Consistent with that evidence, the Federal Trade Commission has repeatedly found that physician agreement requirements like Georgia's are not justified by legitimate health and

safety concerns.[49] Instead, they effectively make physicians gatekeepers over certified nurse-midwives' entry into their profession and access to the maternity care market.

190. Georgia's midwifery laws make it an outlier among its sister states. According to the National Conference of State Legislatures, Georgia is one of a small minority of states that require certified nurse-midwives to practice pursuant to a written protocol agreement with a physician.

191. Georgia's midwifery laws are also inconsistent with the federal government's own health care standards. The Veterans Administration (VA)—the nation's largest employer of nurses—grants certified nurse-midwives full practice authority. Certified nurse-midwives practicing at VA facilities in Georgia may therefore practice independently, even though state law prohibits them from doing so elsewhere in the state.

192. Georgia is among an even smaller minority of states that bar direct-entry midwife practice. At least some direct-entry midwives practice legally in more than 40 states, including most states that border Georgia.

193. Because the Midwifery Restrictions do not advance safety, and instead exclude skilled providers and limit access to care, they do not bear a real and substantial relationship to public health, safety, or welfare.

B. Georgia's Midwifery Restrictions Entrench Physician Control and Suppress Competition

194. The Midwifery Restrictions place physicians—who provide many of the same maternity care services as midwives—in a position of control over midwifery practice. When their

[49] Fed. Trade Comm'n Staff, Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses, at 36 (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

scope of practice overlaps, physicians and midwives compete in the same market for prenatal, labor, delivery, and postpartum care.

1. The "Normal Childbirth" Physician-Approval and Physician-Involvement Requirements

195. The Midwifery Statute conditions direct-entry midwives' ability to provide care on a physician's determination that a patient will experience a "normal childbirth." O.C.G.A §§ 31-26-1(2), -5.

196. In practice, this delegates to individual physicians control over whether midwives may care for particular patients at all. Physicians have no obligation—and little incentive—to provide such approval.

197. This authority is unreviewable by any government body. It gives individual physicians a veto over whether midwives may serve any particular patient, and ultimately, whether they may practice their profession.

198. The Midwifery Statute also fails to specify when such approval must be obtained. Because pregnancy conditions can change over time, this lack of clarity leaves midwives without notice of when physician approval is required, exposing them to arbitrary enforcement even when they act in good faith.

199. The statute reinforces physician control throughout labor and delivery, extending physician authority beyond approval of particular patients. It is vague as to the scope of required physician "direction and supervision," or what it means for a newborn not to be delivered within a "reasonable time." Although midwives seek collaborative relationships with physicians and other providers, these provisions do not facilitate meaningful collaboration. Instead, they condition midwives' ability to provide care on physicians who have no corresponding obligation to collaborate or be available. Midwives nonetheless remain legally responsible for complying with

requirements that depend on physician involvement, exposing them to liability and potential criminal penalties for circumstances beyond their control.

2. The Protocol Agreement Requirements

200. The State likewise makes physicians the gatekeepers for certified nurse-midwives. Through mandatory written Protocol Agreements, physicians control whether certified nurse-midwives may enter or remain in practice and on what terms.

201. Physicians may demand substantial fees or other concessions in exchange for entering such agreements, allowing them to extract noncompetitive prices and shift costs onto families.

202. The Protocol Agreement Requirements also effectively give physicians control over the scope of certified nurse-midwife practice. The statutes identify "medical acts," "medical treatments," "medical devices," and "diagnostic studies" as services that may be performed only if authorized by a physician. To the extent providing these services without physician authorization is considered the "practice of medicine," nurse-midwives risk felony penalties when providing them. *See* O.C.G.A. §§ 43-34-23(d), 43-34-42(a).

203. These terms are either undefined or so broadly defined that they provide no meaningful limits or guidance about what services fall within these categories. For example, one Protocol Agreement statute defines "diagnostic study" as a "laboratory test, X-ray, ultrasound, or procedure used to identify a characteristic or distinguishing feature of a particular disease or condition," a definition so expansive that it effectively imposes no limits. *Id.* § 43-34-25(a)(6).

204. Other key terms—"medical acts," "medical treatments," and "medical devices"—are not defined at all. *Id.* §§ 43-34-23(a), 43-34-25(a). These terms may encompass routine aspects of midwifery care: monitoring maternal vital signs, fetal monitoring, suturing vaginal tears, or providing non-pharmacological pain management. Common tools such as stethoscopes, blood

pressure cuffs, ultrasounds, and fetal dopplers may likewise be treated as "medical devices" requiring physician delegation.

205. At the same time, the Protocol Agreement statutes state that they do not limit nursing practice, and that certified nurse-midwives are not required to enter into a Protocol Agreement to practice. In theory, these provisions preserve the ability of certified nurse-midwives to practice autonomously. In practice, the vague and undefined terms leave certified nurse-midwives unsure what services within their scope require a Protocol Agreement, chilling midwife practice.

206. By leaving these determinations to individual physicians rather than establishing clear standards, the State fails to provide fair notice, invites arbitrary enforcement, and effectively delegates to physicians the authority to regulate midwifery practice. Nor is there any meaningful government oversight: no government body retains authority to monitor physicians' decisions as to whether to enter Protocol Agreements or whether the terms give physicians too much control over midwives' practice.

3. The Georgia Composite Medical Board Rules Exacerbate the Problem

207. The rules of the Georgia Composite Medical Board further entrench physician control over midwifery practice.

208. Those rules require the delegating physician to determine what services performed by a certified nurse-midwife are commensurate with the midwife's "education, training, experience, and competence," and within their "scope of practice, specialty area or field and certification," making the physician the arbiter of what services the midwife may provide. Ga. Comp. R. & Regs. 360-32-.05(3). Disagreement between the certified nurse-midwife and the physician can constrain the midwife's lawful practice.

209. The Board's rules and practices also impose administrative requirements unrelated to patient care and discourage physicians from entering Protocol Agreements under O.C.G.A § 43-34-25.

210. Physicians must initiate and submit Protocol Agreements, and certified nurse-midwives cannot complete an application unless a physician first does so. Ga. Comp. R. & Regs. 360-32-.03(1). If a certified nurse-midwife seeks to change physicians, an entirely new Protocol Agreement must be executed and approved, and the Board charges a fee for each submission.

211. Physicians must also conduct and document annual on-site oversight; review and sign patient records in specified categories—including all records involving controlled substances and adverse outcomes—and review a portion of all other patient records. Ga. Comp. R. & Regs. 360-32-.02(7)(a). Physicians are subject to discipline for noncompliance. *Id.* 360-32-.06.

212. These obligations serve as regulatory burdens on physicians rather than patient protection. They reduce physicians' willingness to enter into Protocol Agreements and limit certified nurse-midwives' ability to practice.

213. The resulting administrative complexity is so substantial that some certified nurse-midwives practice under the more restrictive Protocol Agreement scheme under O.C.G.A. § 43-34-23.

214. Although hospital or large institutional practices may be able to manage these administrative burdens, they tend to treat certified nurse-midwives as "physician extenders" rather than as autonomous practitioners trained to provide independent care.

215. The Georgia Composite Medical Board reviews and approves Protocol Agreements under O.C.G.A § 43-34-25 even though it does not license or regulate certified nurse-midwives. The Board is composed overwhelmingly of physicians—13 of its 15 members are physicians—

and includes no advanced practice registered nurses. As a result, midwives' direct marketplace competitors exert regulatory control over the conditions under which they practice.

4. Market Effects

216. Georgia law suppresses competition in maternity care in two complementary ways. First, the State excludes direct-entry midwives entirely from lawful practice, preventing a class of trained maternity care providers from entering the market. Even if permitted to enter the market, their participation is subject to physician approval. Second, the State conditions certified nurse-midwife practice on physician authorization.

217. Individually and together, these restrictions delegate control over midwifery practice to the very professionals with whom midwives compete—allowing physicians to control both entry into the midwifery profession and the scope of services midwives may provide, reducing competition and limiting the availability of maternity care providers in Georgia.

218. The result is a system in which the supply of midwives is driven not by patient demand but by physicians' willingness to permit their competitors to practice.

C. Georgia's Midwifery Restrictions Shrink the State's Maternity Care Workforce and Deny Pregnant People and Families Access to Safe Midwifery Care

219. As a result of Georgia's laws, trained midwives like Amani, Taitt, and Stokely, either leave the State, limit their midwifery practice, or never enter its maternity care workforce, leaving pregnant Georgians with too few providers. Midwives who specialize in out-of-hospital birth may not lawfully attend home births or staff Georgia birth centers, threatening existing birth centers and impeding the development of new ones.

220. Certified nurse-midwives cannot establish practices—especially necessary in underserved communities—unless a physician agrees to contract with them. If a physician retires,

relocates, or withdraws from an agreement, the midwifery practice that depends on that agreement must find another physician or may be forced to close, leaving individuals without their provider.

221. Research confirms the predictable consequences of these restrictions: states with fewer barriers to midwifery practice have more midwives practicing and greater access to maternity care, particularly in rural and underserved areas.

222. The consequences are especially severe in Georgia, which already faces significant hospital closures and provider shortages.

223. The effects of resulting gaps fall directly on pregnant people and families across Georgia.

224. Pregnant people lack adequate access to providers trained to attend low-risk births in home and birth centers. Although home birth is legal, many physicians and certified nurse-midwives are not trained to attend births outside of hospital settings. Georgia thus creates a troubling paradox: those who choose home birth may be forced to rely on a provider without specialized training or to birth without a skilled practitioner.

225. The restrictions also limit access to midwifery models of care that prioritize low-intervention birth, continuity of care throughout pregnancy, labor, and the postpartum period, and flexibility to accommodate cultural traditions, family participation, and preferences about how and where to give birth.

226. Instead, Georgia funnels pregnant people into hospital-based, physician-managed obstetric care—even when their pregnancies are low-risk, and they would otherwise choose midwifery care or to birth at home or in a birth center.

227. The Midwifery Restrictions also undermine coordination of care. Midwives fear prosecution when communicating with hospital providers or accompanying patients during

hospital transfers, which discourages open collaboration and fragments care during critical moments.

228. Georgia's Midwifery Restrictions suppress a trained workforce without improving safety. Criminalizing direct-entry midwives and conditioning certified nurse-midwives' practice on physician approval reduces the number of providers, limits access to care, and denies pregnant people and families meaningful choices about pregnancy and birth.

CAUSES OF ACTION

229. The Midwifery Restrictions exclude skilled midwives from practice and place control of the profession in the hands of physicians, their competitors in the maternity care market. They violate multiple, independent guarantees of the Georgia Constitution: by imposing arbitrary and unreasonable restrictions on the right to practice, treating similarly situated providers differently, delegating regulatory authority without adequate standards, vesting control of the profession in private actors, mandating anti-competitive agreements, and failing to provide clear and enforceable rules.

COUNT I

Due Process – Right to Practice One's Chosen Profession

230. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

231. The Due Process guarantee in the Georgia Constitution provides that "[n]o person shall be deprived of life, liberty, or property except by due process of law." Ga. Const. art. I, § I, ¶ I.

232. This guarantee protects the right to pursue a chosen, lawful professional calling free from arbitrary, irrational, unreasonable, or oppressive government interference. *Raffensperger v. Jackson* (*Jackson II*), 316 Ga. 383, 388 (2023). Restrictions on the ability to practice a profession

must bear a real and substantial relation to public health, safety, or welfare. *Rockdale Cnty. v. Mitchell's Used Auto Parts, Inc.*, 243 Ga. 465 (1979); *see also Jackson II*, 316 Ga. at 392.

233. Midwifery is a lawful profession in Georgia. *See* O.G.C.A. §§ 31-26-1, *et seq*.,43-26-3, 43-34-23, and 43-34-25; Ga. Comp. R. & Regs. 410-11-.01, -.02.

234. The Midwifery Restrictions deprive Plaintiffs of the ability to practice their chosen, lawful profession, in violation of the Georgia Constitution.

Prohibition on Direct-Entry Midwives

235. First, DPH Rules restrict the practice of midwifery to certified nurse-midwives, categorically prohibiting direct-entry midwives from practicing, regardless of their skills, training, or experience.

236. The categorical prohibition bears no real and substantial connection to public health, safety, or welfare. There is no credible evidence that a nurse-midwife credential is necessary to practice midwifery or that criminalizing direct-entry midwives protects the public.

237. Instead, the prohibition affirmatively harms the public health, safety, and welfare by excluding an entire category of skilled midwives—who specialize in low-risk pregnancy and out-of-hospital birth—and exacerbates Georgia's shortage of maternity care providers.

"Normal Childbirth" Physician-Approval and Physician-Involvement Requirements

238. Second, the Midwifery Statute conditions the ability of direct-entry midwives to practice their profession on a physician-conducted physical examination verifying that the individual will experience a "normal childbirth," and physician involvement throughout labor and delivery.

239. The physician-approval requirement prevents direct-entry midwives from independently assessing whether a prospective patient falls within their scope of practice. Instead,

it gives physicians—who compete with midwives—control of whether midwives may care for particular individuals, regardless of the midwives' skill, training, and experience.

240. The statute's physician-involvement requirements likewise prohibit midwives from performing core clinical functions absent physician direction and supervision, and require physician notification in certain circumstances. These provisions extend physician control into the core of midwifery practice, making the provision of care dependent on physician involvement.

241. These requirements bear no real and substantial connection to public health, safety, or welfare. Midwives are trained to determine whether individuals fall within their scope of practice and to consult or to transfer individuals who do not. Requiring physician approval and involvement does not ensure meaningful collaboration or improve safety, and instead substantially interferes with midwives' ability to practice their profession and diminishes access to maternity care, which is already scarce.

Protocol Agreement Requirements for Certified Nurse-Midwives

242. Third, the Protocol Agreement Requirements compel certified nurse-midwives to enter into written agreements with physicians to practice their profession.

243. Without such agreements, certified nurse-midwives cannot perform substantial aspects of nurse-midwifery practice or practice as certified nurse-midwives at all.

244. Although Georgia law otherwise authorizes certified nurse-midwives, as advanced practice nurses, to perform the full scope of certified nurse-midwifery practice, the Protocol Agreement Requirements make the ability to practice contingent on physician approval. *See* O.C.G.A. § 43-26-3(1), (1.1); Ga. Comp. R. & Regs. 410-11-.01, and 410-11-.02(2)(a).

245. As a result, physicians—who compete with midwives—control whether and how certified nurse-midwives may practice. Their consent depends not on the midwife's qualifications or competence, but on a physician's willingness to enter an agreement and the terms imposed. This

requirement effectively gives physicians authority over whether certified nurse-midwives can enter or remain in the profession and what services they may provide.

246. The Protocol Agreement Requirements bear no real and substantial connection to public health, safety, or welfare. There is no credible evidence that requiring physician supervision improves safety, and evidence shows that certified nurse-midwives practice safely and effectively with full practice authority.

247. Instead, the Requirements primarily protect the economic well-being of physicians at the expense of midwives and the pregnant people who wish to use their services. They affirmatively harm the public health, safety, and welfare by erecting unnecessary barriers to certified nurse-midwife practice, forcing certified nurse-midwives to restrict their practice or driving them out of practice, and further reducing access to maternity care in Georgia.

COUNT II

Equal Protection

248. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

249. The Georgia Constitution's equal protection clause provides that "[p]rotection to person and property is the paramount duty of government and shall be impartial and complete. No person shall be denied the equal protection of the laws." Ga. Const., art. 1, § I, ¶ II.

250. Equal protection requires "that the State treat similarly situated individuals in a similar manner." *Bell v. Austin*, 278 Ga. 844, 846 (2005) (citation and punctuation omitted).

251. A law that treats similarly situated individuals differently is subject to strict scrutiny "if it either operates to the disadvantage of a suspect class or interferes with the exercise of a fundamental right." *Ambles v. State*, 259 Ga. 406, 407 (1989). When no fundamental right or suspect class is involved, classifications must be "based on rational distinctions and bear[] a direct

relationship to the purpose of the legislation." *Grissom v. Gleason*, 262 Ga. 374, 377 (1992).

252. The Midwifery Restrictions create impermissible classifications among similarly situated maternity care providers and violate Plaintiffs' equal protection rights.

253. Individuals are similarly situated when they perform the same core work, even if they receive different training or hold different credentials. *Jackson v. Raffensperger* (*Jackson I*), 308 Ga. 736, 742 (2020).

254. Direct-entry midwives, certified nurse-midwives, and physicians all provide maternity care—including prenatal care, labor and delivery services, and postpartum care—to overlapping populations.

255. Georgia law establishes two classifications in its regulation of these similarly situated maternity care providers.

256. First, direct-entry midwives and certified nurse-midwives are similarly situated because both practice midwifery and provide maternity care, including prenatal care, labor and delivery management, and postpartum care for low-risk pregnancies. Yet Georgia law permits certified nurse-midwives to practice—albeit subject to the Protocol Agreement requirements—while prohibiting direct-entry midwives from practicing entirely.

257. Second, midwives and physicians are similarly situated with respect to maternity care. Both provide prenatal, intrapartum, and postpartum care, and both are trained to identify complications and refer or transfer individuals when more complex levels of care are needed. Yet, physicians may practice autonomously, while direct-entry midwives are barred from practice, and certified nurse-midwives may practice only with physician approval through Protocol Agreements.

258. Although midwives and physicians receive different training and may practice different models of care, those differences do not void their similarly situated status. Both are

qualified to provide maternity care within their respective scopes of practice, and the State may not evade equal protection review by defining providers at different levels of generality when they perform the same core function.

259. The Midwifery Restrictions do not account for differences between midwives and physicians. Instead, the State prohibits midwives from practicing or conditions their practice on physician control, rather than permitting them to provide care consistent with their training.

260. The State's classifications bear no real and substantial connection to public health, safety, or welfare. Instead, they restrict the availability of midwifery care to the people of Georgia, limit the ability of trained midwives to practice their profession, and operate to protect physicians' control over maternity care.

261. The Midwifery Restrictions reduce access to trained maternity care providers, including those specializing in low-intervention and out-of-hospital birth.

COUNT III

Nondelegation – Separation of Powers

262. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

263. The Midwifery Statute violates Plaintiffs' rights by unlawfully delegating legislative authority without adequate standards and DPH's actions violate their rights by unlawfully delegating authority to the Board of Nursing.

General Assembly's Delegation to DPH

264. The Georgia Constitution requires that legislative, executive, and judicial powers "remain separate and distinct." Ga. Const. art. I, § II, ¶ III.

265. Consistent with that separation, the nondelegation doctrine prohibits the General Assembly from conferring authority without "sufficiently objective, judicially enforceable

guidelines to direct and cabin the agency's exercise of . . . discretion." *Nat'l Comm. v. Eternal Vigilance Action, Inc.*, 321 Ga. 771, 798 (2025).

266. The Georgia Midwifery Statute provides that "No person shall practice midwifery without first receiving from [DPH] a certificate of authority . . . ." O.C.G.A. § 31-26-2(a).

267. Although the Statute lists general eligibility criteria—such as health status, completion of training, and passing an exam—it provides no meaningful standards governing the education, examination, or qualifications required for a certificate. *Id.* § 31-26-2(b)–(c).

268. Instead, it grants DPH authority to adopt whatever rules it deems "necessary and proper" to carry out the Statute. *Id.* § 31-26-3.

269. This open-ended grant of authority provides no objective or enforceable guidelines to cabin an agency's exercise of discretion. *See Nat'l Comm.*, 321 Ga. at 797–98.

270. The delegation is impermissibly broad and effectively transfers legislative power to DPH in violation of the Georgia Constitution.

DPH's Delegation to the Board of Nursing

271. The General Assembly vested DPH—not any other entity—with the authority to establish and administer a system for certifying midwives. O.C.G.A. § 31-26-2.

272. Rather than exercising that authority, DPH promulgated a regulation requiring midwives to obtain certification from the Board of Nursing as certified nurse-midwives. Ga. Comp. R. & Regs. 511-5-1-.02.

273. DPH maintains no authority over the Board of Nursing and its regulation provides the Board with no standards to guide its decision-making; instead, it incorporates the Board's own regulatory framework for nurse-midwives. *See id.* (citing Board of Nursing "Rules for Certified Nurse-Midwives").

274. In doing so, DPH has effectively transferred its regulatory authority over midwifery to the Board of Nursing—an entity not authorized by the legislature to define or control entry into the midwifery profession.

275. The regulation also expands the Board of Nursing's enforcement power by subjecting midwifery practice to the laws governing nurse-midwifery, without legislative authorization. *Id.*

276. The delegation also fails to ensure meaningful public accountability. Although the Board of Nursing is a public body, it is not accountable to DPH and operates outside of DPH's control. DPH is statutorily responsible for regulating midwifery, but lacks control, while the Board exercises authority without being answerable to DPH or subject to its review procedures. *See id.* 511-5-1-.01(1) and 410-14-.01.

277. This delegation of authority violates the nondelegation doctrine and separation of powers. Ga. Const. art. I, § II, ¶ III.

COUNT IV

Ultra Vires

278. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

279. An act is ultra vires when a government entity "acts with the total absence or want of power to do so," and thus, the act is without legal effect. *Jester v. Red Alligator, LLC*, 344 Ga. App. 15, 23 (2017) (internal citation omitted).

280. The DPH Rules violate Plaintiffs' rights because they are ultra vires and exceed the authority granted to DPH by the General Assembly.

281. The Midwifery Statute vests DPH—and only DPH—the authority to issue, deny, suspend, or revoke certificates of authority to midwives in Georgia. O.C.G.A. § 31-26-2(a), (d).

282. The Statute authorizes DPH to establish minimum requirements, procedures, and standards governing the practice of midwifery. *Id.* § 31-26-3.

283. The Board of Nursing regulates certified nurse-midwives as advanced practice nurses. But the General Assembly did not authorize the Board of Nursing to define or control entry into the profession of midwifery by those who are not nurses.

284. Rather than exercising its statutory authority, DPH promulgated a regulation requiring individuals to obtain certification from the Board of Nursing as certified nurse-midwives to practice midwifery. Ga. Comp. R. & Regs. 511-5-1-.02.

285. In doing so, DPH transferred its statutory authority to regulate midwifery to the Board of Nursing, a separate, non-subordinate agency.

286. The General Assembly authorized none of this: it did not authorize DPH to abandon its duty to regulate midwives other than certified nurse-midwives, to transfer its statutory authority to the Board of Nursing, or to expand the Board's jurisdiction over midwifery practice.

287. By purporting to delegate or transfer authority to the Board of Nursing, DPH has engaged in an "unconstitutional usurpation of the General Assembly's power." *N. Fulton Med. Ctr. v. Stephenson*, 269 Ga. 540, 543 (1998).

COUNT V

Nondelegation – Delegation to Private Parties

288. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

289. The General Assembly has the "power to make all laws" not inconsistent with the Georgia Constitution "which it shall deem necessary and proper for the welfare of the state. Ga. Const. art. III, § VI, ¶ I.

290. That authority may not be delegated to private parties. The General Assembly may

not confer regulatory power on private actors whose decisions are not subject to meaningful governmental standards or review. *Consumers' Rsch., Cause Based Com., Inc. v. Fed. Commc'ns Comm'n*, 88 F.4th 917, 926 (11th Cir. 2023) (holding that governmental delegations to private parties are only permissible where the private entity "functions subordinately to the agency," and the agency retains "authority and surveillance over the activities of the private entity") (citation modified). Such delegations are especially egregious when the private delegate has a pecuniary interest in their delegated function. *E.g.*, *Texas Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454, 469, 472 (Tex. 1997).

291. The Midwifery Statute and the Protocol Agreement Requirements violate Plaintiffs' rights by improperly vesting regulatory authority in private physicians to control whether midwives may practice and on what terms.

292. The General Assembly exercised its authority by recognizing midwifery as a lawful profession and establishing statutory frameworks governing its practice.

293. Through the Midwifery Restrictions, however, the General Assembly has unconstitutionally delegated to private physicians the power to determine whether, and under what terms, midwives may practice their profession.

Delegation to Physicians Through the "Normal Childbirth" Physician-Approval and Physician-Involvement Requirements

294. The Midwifery Statute permits direct-entry midwives to attend births only where a physician has conducted a physical examination and determined that the individual will experience a "normal childbirth." O.C.G.A. §§ 31-26-1(2), 31-26-5.

295. This gives private physicians the authority to decide whether an individual falls within a midwife's permissible scope of practice and, in turn, whether a direct-entry midwife may provide care.

296. As a result, physicians—who may compete with midwives for patients—exercise unbounded discretion over whether direct-entry midwives may practice. By conditioning a midwife's ability to provide care on a physician's determination that a "normal childbirth" will occur, the law effectively vests physicians with the ultimate authority to regulate the midwifery profession.

297. The statute extends this delegation into labor and delivery, by making midwives' ability to perform certain functions contingent on physician direction and supervision, and mandating physician notification in certain circumstances. It imposes no standards governing physicians' decisions and no requirement that they be available. Yet midwives remain subject to liability for noncompliance.

Delegation to Physicians Through the Protocol Agreement Requirements

298. The Protocol Agreement Requirements condition certified nurse-midwives' ability to practice on entering into agreements with physicians. *Id.* §§ 43-34-23, 43-34-25.

299. Without such agreements, certified nurse-midwives cannot perform core aspects of their practice or practice as nurse-midwives at all.

300. These requirements give private physicians the power to determine whether certified nurse-midwives may enter or remain in the profession and what services they may provide.

301. As a result, physicians exercise discretionary control over certified nurse-midwives' ability to practice, based on their own economic interests or preferences rather than objective regulatory standards.

302. By vesting private physicians with gatekeeping authority over entry into and practice within the midwifery profession, the General Assembly has delegated core regulatory power to private actors.

303. Neither delegation includes adequate standards, safeguards, and accountability and both are therefore unconstitutional.

COUNT VI

Anti-Competition Clause

304. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

305. The Georgia Constitution's Anti-Competitive Contracts Clause provides that "[t]he General Assembly shall not have the power to authorize any contract or agreement which may have the effect or which is intended to have the effect of defeating or lessening competition, or encouraging a monopoly, which are hereby declared to be unlawful and void." Ga. Const. art. III, § VI, ¶ V(c)(1).

306. The Protocol Agreement Requirements violate Plaintiffs' rights by mandating agreements that suppress competition among maternity care providers.

307. The Protocol Agreements required by statute are "contracts between service providers"—i.e., certified nurse-midwives and physicians—and thus implicate this prohibition. *See Women's Surgical Ctr., LLC v. Berry*, 302 Ga. 349, 354 (2017).

308. These requirements give physicians the power to determine whether certified nurse-midwives may practice and on what terms.

309. Physicians may refuse to enter into Protocol Agreements, impose fees, or require restrictive conditions, thereby limiting certified nurse-midwife ability to provide care and restricting access to midwifery services.

310. By requiring certified nurse-midwives to enter into agreements that have the effect of lessening competition, the General Assembly has authorized contracts in violation of the Georgia Constitution.

COUNT VII

Due Process – Vagueness

311. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

312. The Georgia State Constitution guarantees that "[n]o person shall be deprived of life, liberty, or property except by due process of law." Ga. Const. art. I, § I, ¶ I. A law is unconstitutionally vague and violates the right of due process when it is "so vague that persons of common intelligence must necessarily guess at its meaning and differ as to its application." *Gouge v. City of Snellville*, 249 Ga. 91, 93 (1982) (internal citation omitted).

313. The Midwifery Statute and Protocol Agreement Requirements violate Plaintiffs' rights by failing to provide clear notice or enforceable standards governing midwifery practice.

314. Because the statutes carry criminal penalties and implicate constitutional rights, including midwives' rights to practice their chosen profession without arbitrary discrimination or enforcement, heightened clarity is required. *See, e.g.*, *Satterfield v. State*, 260 Ga. 427 (1990) (in a vagueness challenge, there is "greater tolerance of enactments with civil rather than criminal penalties because the consequences of imprecision are qualitatively less severe.").

"Normal Childbirth" Physician-Approval and Physician-Involvement Requirements

315. The Midwifery Statute requires that direct-entry midwives only attend "normal childbirth." O.G.C.A. § 31-26-5. It defines "normal childbirth" as "delivery, at or close to term, of a pregnant woman whose physical examination by a physician reveals no abnormalities and who does not have signs or symptoms of hemorrhage, toxemia, infection, abnormal position or presentation, or prolonged labor. *Id.* § 31-26-1(2).

316. The statute fails to specify when the required physician examination must occur. It does not state whether the examination must occur during pregnancy, immediately before labor, at the onset of labor, or at another time.

317. Nor does the statute clarify how long such an examination remains valid or whether changed clinical circumstances require a new examination.

318. The statute is also vague as to the scope of required physician involvement during labor and delivery. It does not define what constitutes sufficient physician "direction and supervision." And it requires midwives to notify a physician if a newborn is not delivered within a "reasonable time," without defining that term.

319. As a result, direct-entry midwives must guess whether and when physician approval is required to comply with the law, particularly challenging given that pregnancy conditions may change.

320. This lack of clarity subjects direct-entry midwives to potential liability based on undefined and shifting requirements and invites arbitrary enforcement.

Protocol Agreement Requirements

321. The Protocol Agreement Statutes O.C.G.A. §§ 43-34-23 and 43-34-25 similarly use vague and undefined terms, including "diagnostic studies," "medical acts," "medical devices," and "medical treatments."

322. Although "diagnostic study" is defined in O.C.G.A. § 43-34-25(a)(6) as "laboratory test, X-ray, ultrasound, or procedure used to identify a characteristic or distinguishing feature of a particular disease or condition," that definition does not provide adequate notice to certified nurse-midwives about the line between permissible and prohibited conduct.

323. The statutes do not define "medical acts," "medical treatments," and "medical devices," leaving certified nurse-midwives without clear notice of what care they may provide

within their scope, absent a Protocol Agreement.

324. As a result, certified nurse-midwives must guess at the scope of lawful practice and risk sanction for engaging in conduct that may fall within their training and licensure.

325. Absence of clear guidance also invites arbitrary and discriminatory enforcement against certified nurse-midwives.

COUNT VIII

Declaratory Judgment

326. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

327. An actual, present, substantial, and judicial controversy exists between Plaintiffs and Defendant as to whether the following Midwifery Restrictions are, as more fully alleged above, unlawful and void under the Georgia Constitution:

a. The Midwifery Statute, O.C.G.A. § 31-26-1 *et seq.*;

b. The DPH Rules, Ga. Comp. R. & Regs. 511-5-1-.02; and

c. The Protocol Agreement Requirements, O.C.G.A. §§ 43-34-23 and 43-34-25, and implementing regulations.

328. But for the foregoing, unlawful Midwifery Restrictions, Plaintiffs would engage in the practice of midwifery in Georgia.

329. Plaintiffs are therefore entitled to a declaration that the foregoing Midwifery Restrictions are unlawful and void. O.C.G.A. § 9-4-2(a).

330. Plaintiffs are also entitled to a declaration that the foregoing Midwifery Restrictions are unlawful and void because the ends of justice require that such a declaration should be made to protect their rights under the Georgia Constitution and statute. *Id.* § 9-4-2(b); *see also* Ga.

Const., art. I, § II, ¶ V(b)(1) (waiving sovereign immunity as to injunctive relief only "after awarding declaratory relief").

COUNT IX

Permanent Injunction

331. Plaintiffs reallege and incorporate by reference the allegations contained in all of the preceding paragraphs.

332. Because, as more fully alleged above, the Midwifery Restrictions are unlawful and void under the Georgia Constitution, and are causing Plaintiffs substantial and irreparable harm, Plaintiffs are entitled to a permanent injunction restraining Defendant from enforcing or taking any action to enforce:

1. The Midwifery Statute, O.C.G.A. § 31-26-1 *et seq.*;
2. The DPH Rules, Ga. Comp. R. & Regs. 511-5-1-.02;
3. The Protocol Agreement Requirements, O.C.G.A. §§ 43-34-23 and 43-34-25, and their implementing regulations.

333. But for the threat of enforcement of the foregoing, unlawful Midwifery Restrictions, Plaintiffs would engage in the practice of midwifery.

334. Any enforcement of the foregoing Midwifery Restrictions against Plaintiffs would be illegal and contrary to equity and good conscience. O.C.G.A. § 9-5-1.

335. Plaintiffs have no other adequate remedy at law to enforce their rights under the Georgia Constitution and statute to participate in the lawful occupation of their choosing. *Id.*

RELIEF REQUESTED

Wherefore, Plaintiffs respectfully request the Court grant the following relief:

a. Declare that the Midwifery Restrictions violate Article I, Section I, Paragraph I of the Georgia Constitution and are therefore unlawful and void.

b. Declare that the Midwifery Restrictions violate Article I, Section I, Paragraph II of the Georgia Constitution and are therefore unlawful and void.

c. Declare that the Midwifery Restrictions violate Article I, Section II, Paragraph III of the Georgia Constitution and are therefore unlawful and void.

d. Declare that the DPH Rules are in excess of DPH's statutory authority under O.C.G.A. § 31-26-2 and are therefore unlawful and void.

e. Declare the Midwifery Restrictions violate Article II, Section VI, Paragraph I and are therefore unlawful and void.

f. Declare that the Protocol Agreement Requirements, as applied to certified nurse-midwives, violate Article III, Section VI, Paragraph V(c)(1) of the Georgia Constitution and are therefore unlawful and void.

g. Enter a permanent injunction consistent with the declaratory relief listed above, restraining Defendant from enforcing the Midwifery Restrictions.

h. Enter an order that the State of Georgia take all steps to necessary comport with the orders for declaratory and injunctive relief.

i. Award Plaintiffs their reasonable attorneys' fees and costs in this action pursuant to O.C.G.A. § 9-4-9.

j. Order any further relief to which Plaintiffs may be entitled or the Court deems just and proper.

RESPECTFULLY SUBMITTED, this 2nd day of April, 2026.

/s/ Andrew Canter
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**Pro hac vice application forthcoming*