CASE NO. CL-2025-0419

IN THE COURT OF CIVIL APPEALS OF ALABAMA

ALABAMA DEPARTMENT OF PUBLIC HEALTH; SCOTT HARRIS, in his official capacity as the State Health Officer of the Alabama Department of Public Health,

Defendants-Appellants,

v.

OASIS FAMILY BIRTHING CENTER, LLC, on behalf of itself and its patients; HEATHER SKANES, M.D., on behalf of herself and her patients; ALABAMA BIRTH CENTER; YASHICA ROBINSON, M.D., on behalf of herself and her patients; ALABAMA AFFILIATE OF THE AMERICAN COLLEGE OF NURSE MIDWIVES, on behalf of its members; JO CRAWFORD, CPM, on behalf of herself and her patients; TRACIE STONE, CPM, on behalf of herself and her patients,

Plaintiffs-Appellees.

On Appeal from the Circuit Court of Montgomery County, Alabama
Civil Action No. 03-cv-23-901109

BRIEF OF APPELLEES

Oral Argument Requested

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STATEMENT REGARDING ORAL ARGUMENT

Pursuant to Rule 34(a) of the Alabama Rules of Appellate Procedure, Plaintiffs respectfully request oral argument in this case. This case raises important questions of first impression involving the definition of "hospital" under section 22-21-20(1) of the Alabama Code (1975) and whether Defendants are acting within the boundaries the Alabama Legislature set on their authority by attempting to regulate freestanding birth centers as "hospitals." This case also involves issues of significant public importance, as whether Defendants are exceeding the scope of their authority directly affects the ability of licensed health care practitioners to expand access to much-needed health care and improve maternal and infant health outcomes in the State. As such, Plaintiffs respectfully submit that oral argument will aid or assist in this Court's decisional process.

TABLE OF CONTENTS

STATEMENT OF JURISDICTION

This Court has jurisdiction pursuant to section 12-3-10 of the Alabama Code because this appeal involves a "challeng[e] [to] the rules, regulations, orders, actions, or decisions of [an] administrative agenc[y]." *Kimberly-Clark Corp. v. Eagerton*, 433 So. 2d 452, 454 (Ala. 1983); *accord Heckathorn v. City of Homewood*, 398 So. 3d 334, 337 (Ala. Civ. App. 2024).

TABLE OF AUTHORITIES

Cases

Statutes, Rules & Regulations

Other Authorities

STATEMENT OF THE CASE

This appeal arises out of the circuit court's grant of summary judgment, declaratory relief, and a permanent injunction in Plaintiffs' favor on Claim One of Plaintiffs' First Amended Complaint. C. 2929–43.[1] The court held that freestanding birth centers operating in the midwifery model of care ("FSBCs" or "birth centers") are not "hospitals" under section 22-21-20(1) of the Alabama Code, and, therefore, Defendants-Appellants Alabama Department of Public Health ("ADPH") and Scott Harris, State Health Officer (collectively "Defendant"[2]), exceeded their statutory authority in violation of the Alabama Administrative Procedures Act ("AAPA"), Ala. Code § 41-22-10, by attempting to license and regulate them as such. C. 2942–43.

Plaintiffs-Appellees ("Plaintiffs") are:

- two birth centers that are providing midwifery care (including birthing care) in Alabama, Oasis Family Birthing Center

[1] "C." refers to citations to the Clerk's record. Unless otherwise indicated, separate documents within the Clerk's record are divided by a semi-colon. All citations to "Ala. Code" herein are to the Code of Alabama (1975).

[2] As explained *infra*, *see* Argument Section I, Plaintiffs-Appellees agree that ADPH should be dismissed as a defendant, and the case should proceed against Harris in his official capacity as State Health Officer of ADPH. Accordingly, Plaintiffs use the singular "Defendant" throughout.

("OFBC") in Birmingham, and Alabama Birth Center ("ABC") in Huntsville (collectively, "Plaintiff Birth Centers");

- their respective owners, Heather Skanes, M.D., and Yashica Robinson, M.D.;
- individual midwives, Jo Crawford, CPM, and Tracie Stone, CPM, who are providing midwifery care (including birthing care) at OFBC and ABC, respectively[3]; and
- the Alabama affiliate of the American College of Nurse-Midwives ("ACNM-AL"), a membership organization representing Alabama midwives, including midwives who work in, own, and/or seek to work in or open FSBCs in Alabama.

C. 1899–1900, 1905–06; C. 1936, 1942–44, 1946, 1948–49. Plaintiffs filed suit on August 8, 2023. C. 9–54. Plaintiffs alleged that, despite a severe maternal and infant health crisis in the state, *see* C. 21–24, 33–34; C. 962, ADPH was enforcing an unlawful *de facto* ban on birth centers, including threatening Plaintiff OFBC—the only FSBC operating at that time—with penalties as an "unlicensed hospital," resulting in OFBC's June 2023 closure despite a perfect safety record, C. 38–41; C. 970; *see also* C. 36–38, 41–42.

The Complaint alleged six causes of action, including the threshold claim at issue here: that, by attempting to license and regulate FSBCs,

[3] Plaintiffs Crawford and Stone were added in January 2024 to the amended complaint; at that same time, a third birth center and its midwife-owner withdrew from case. C. 1266, 1270–72.

ADPH and Harris exceeded their statutory authority in violation of the AAPA, because Alabama law limits ADPH's authority to only those facilities meeting the definition of a "hospital" under section 22-21-20(1) and FSBCs do not meet that definition ("Claim One"). C. 47. In the alternative, Claims Two through Six asserted that, even assuming Defendant had regulatory authority, the *de facto* ban was unlawful under the AAPA and the Alabama and federal constitutions. C. 48–51. Plaintiffs named as defendants ADPH, *see* Ala. Code § 41-22-10, and Scott Harris, in his official capacity, C. 14–15.

On August 9, 2023, Plaintiffs moved for a preliminary injunction on Claim One and three of their alternative claims (Claims Two through Four). C. 164–75; C. 176–229.

Defendant filed a motion to dismiss all claims on September 8, 2023, C. 707–24. With respect to Claim One, Defendant argued that birth centers operating in the midwifery model of care meet the definition of "hospital" in section 22-21-20(1). C. 712–14. After briefing, *see* C. 501–14; C. 731–67; C. 811–50, the circuit court held an evidentiary hearing and argument on both motions on September 28–29, 2023. *See* C. 421–22; C. 808–10. The court denied Defendant's motion to dismiss from the bench,

thereby rejecting, *inter alia*, Defendant's attempt to dismiss Claim One. *See* C. 851; C. 712–714.

On September 30, 2023, the circuit court entered a preliminary injunction relying on Plaintiffs' alternative Claims Two, Three, and Four and enjoined Defendant from "refusing to timely license (including but not limited to refusing to timely issue temporary or interim licenses to) freestanding birth centers operating in the midwifery model of care . . . that can demonstrate substantial compliance with the standards set out by the American Association of Birth Centers" ("AABC") and generally-applicable statutory requirements for licensure. C. 857–58; *see also* C. 887–88 (description of AABC standards).

In a supplemental order entered on Plaintiffs' motion a week later, *see* C. 902–04; C. 925–43, the circuit court held that Plaintiffs had demonstrated a likelihood of success on their claims that Defendant's *de facto* ban on birth centers violated the AAPA and Plaintiffs' right to pursue useful activities under the Alabama Constitution. C. 936–39.[4]

[4] The circuit court ruled on Plaintiffs' alternative claims without reaching the threshold question under Claim One at issue in this appeal: whether ADPH has licensing or regulatory authority over FSBCs at all. *See, e.g.*, C. 936 (holding that, "even *if* ADPH has licensing authority over birth centers," the *de facto* ban exceeded any such authority (emphasis

The court further held that Plaintiffs had satisfied all other requirements for preliminary injunctive relief. C. 940–43; *see Baldwin Cnty. Elec. Membership Corp. v. Catrett*, 942 So. 2d 337, 344 (Ala. 2006). In particular, the circuit court found based on the testimony and documentary evidence presented at the hearing that: "Alabama is experiencing some of the worst maternal and infant health outcomes in the United States," C. 928, marked by "disparities" and "severely limited availability of pregnancy services," C. 929; that there is "a robust body of reliable evidence supporting the safety" and "meaningful benefits" of midwifery and birth center care, including "fewer cesarean section deliveries," "less preterm birth," "less fetal loss," "increased rates of breastfeeding," "higher patient satisfaction," reductions in disparities in outcomes, and "cost-savings," C. 929; and that the care Plaintiffs intended to offer in birth centers would "help address the dire needs of

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added)); *cf. also Ex parte King*, 591 So. 2d 464, 467 (Ala. 1991) (plaintiffs are permitted to maintain "alternative, inconsistent, [or] mutually exclusive claims" and need not elect between them in preliminary stages of litigation); 1 Gregory C. Cook, Ala. Civ. P. Ann. § 8.7 (5th ed. 2018). Defendant's contention that the preliminary injunction "tacitly acknowledged" ADPH's "jurisdiction over the Plaintiffs" is thus incorrect. Appellants' Br. 10 n.3 [hereinafter "Def. Br."]; *see also* C. 851 (denying motion to dismiss, *inter alia*, Claim One).

their communities," including "the patient populations most at risk of adverse [maternal and infant health] outcomes," C. 942.

On October 15, 2023, ADPH adopted final regulations for the licensure of birth centers. Ala. Admin. Code rr. 420-5-13-.01 to -.19 [hereinafter "the ADPH Regulations"]; C. 1902.[5] On January 19, 2024, Plaintiffs filed a First Amended Complaint, which, *inter alia*, added seven additional alternative claims challenging the content of the ADPH Regulations. C. 997–1061; *see also supra* note 3.

On February 29, 2024, Defendant moved to dismiss Claims One through Five of the Amended Complaint, C. 1374–85, reprising the same arguments as the first motion to dismiss with respect to Claim One, *see* C. 1376–79. After briefing and oral argument, *see* C. 1386; C. 1387–1420, the circuit court again denied dismissal, C. 1856–61.

On October 28, 2024, the parties jointly proposed to cross-move for summary judgment on Claim One, which, if resolved in Plaintiffs' favor, would be dispositive of the entire action and avoid unnecessary proceedings on Plaintiffs' alternative claims. C. 1888–92; C. 1897–98.

[5] Under the preliminary injunction, compliance with AABC standards—not the ADPH Regulations—was required to obtain a temporary license. *See* C. 857–58; C. 1945–46.

The parties entered joint stipulations of fact in conjunction with the cross-motions. C. 1899–1908. On January 15, 2025, Defendant moved for summary judgment on Claim One, relying solely on the stipulated facts. C. 1909–10; C. 1911–24. On February 5, 2025, Plaintiffs opposed Defendant's motion and cross-moved for summary judgment on Claim One, relying on the stipulations, as well as affidavits and other documents, pursuant to Rule 56(c)(1) and (e) of the Alabama Rules of Civil Procedure. C. 1925–28; C. 1929–75; *see* C. 1976–2371 (Plaintiffs' affidavits and documentary exhibits). On February 25, 2025, Defendant filed a cross-opposition and reply, C. 2373–79, in which he did not dispute any of Plaintiffs' factual submissions, C. 2373–74. On March 19, 2025, Plaintiffs filed a reply. C. 2380–94.

After oral argument on April 21, 2025, the circuit court granted Plaintiffs' motion for summary judgment on Claim One, entered declaratory and injunctive relief, and denied Defendant's motion. C. 2929–43. The court held that birth centers operating in the midwifery model of care are not "primarily engaged in offering to the public generally . . . obstetrical care," Ala. Code § 22-21-20(1), and, therefore,

such birth centers "are beyond the scope of ADPH's statutory authority to license and regulate," C. 2934–35.

On May 26, 2025, on Defendant's unopposed motion, *see* C. 2944–46, the circuit court certified its order as final under Rule 54(b) of the Alabama Rules of Civil Procedure, C. 2949–51. Defendant noticed this appeal on June 6, 2025. C. 2952–54. On June 11, 2025, the circuit court stayed further proceedings on Plaintiffs' remaining claims pending the outcome of this appeal. C. 2962.

STATEMENT OF THE ISSUES

I. Is the Alabama Department of Public Health entitled to sovereign immunity in this action?

II. Did the circuit court correctly conclude that Defendant lacks statutory authority to license and regulate birth centers operating in the midwifery model of care as "hospitals" under section 22-21-20(1) where, based on ordinary principles of statutory interpretation and the undisputed facts, such birth centers do not fall within that definition for two independent reasons:

   A. they are not "primarily engaged in offering . . . obstetrical care" because midwifery care is legally and factually different from "obstetrical care"; and

   B. they do not provide care to "the public generally" because they serve only a subset of pre-screened, eligible patients based on strict criteria and provider discretion?

III. Did the circuit court correctly grant a permanent injunction where Plaintiffs established success on the merits under the AAPA and it is uncontested that they satisfied the remaining traditional injunction factors?

STATEMENT OF THE FACTS

The material facts, which the circuit court incorporated into its order, C. 2931, are established by the parties' joint stipulations, C. 1899–1908, as well as affidavits and documents put forward by Plaintiffs, *see* C. 1932–55; C. 1976–2371 (exhibits), and which Defendant did not dispute, C. 2373–74; *see Ala. Dep't of Revenue v. Greenetrack, Inc.*, 369 So. 3d 640, 657 (Ala. 2022) (where opposing party fails to dispute moving party's facts, the court "must consider [the] evidence uncontroverted" (internal quotation marks and citation omitted)); Ala. R. Civ. P. 56(e).

A. Alabama's Maternal and Infant Health Crisis

According to ADPH's own admissions and data, Alabama is experiencing "an urgent maternal and infant health crisis," C. 1939 (statement by Defendant Harris), marked by some of the worst outcomes in the United States, C. 1939–40. Alabama's maternal death rate in 2020 and 2021 was 36.4 deaths per 100,000 live births, the third and sixth highest in the U.S. for those years, and the infant mortality rate increased from 6.7 deaths per 1,000 in 2022 (then the twelfth highest in the country) to 7.8 per 1,000 in 2023, C. 1939–40. More than 60% of pregnancy-related deaths documented in ADPH's most recent maternal

mortality review were preventable. C. 1939. Preterm birth and low birthweight affect more than 10% of all babies born in the state and are among the leading causes of infant death in Alabama. C. 1940.

These risks are not borne equally: Defendant Harris has stated that there is an "enduring disparity between birth outcomes for Black and [W]hite mothers" in Alabama, with mortality rates for Black mothers and babies two-to-three times higher than for White Alabamians. C. 1940. Black babies in Alabama are twice as likely as White babies to be born with low birthweight and to die from causes related to preterm birth and low birthweight before their first birthday. C. 1940. Low-income families also experience disproportionately poor outcomes: more than half of maternal and infant deaths in recent years occurred among Medicaid-insured populations. C. 1940.

Defendant admits that "inadequate access to pregnancy-related care, especially prenatal care, is a significant driver of maternal and infant mortality, increasing the risk of preterm birth and low birthweight." C. 1941. More than two-thirds of Alabama counties lacked adequate access to pregnancy-related care as of 2022, with 37.3% classified as "maternity care deserts" lacking *any* hospitals, birthing

centers, obstetricians, or nurse-midwives, and an additional 31.3% with only low or moderate access. C. 1941. Nearly 60% of Alabama counties lacked any hospital-based obstetrical care as of May 2024, and Defendant admits that hospital labor and delivery units across the state are closing "at an alarming rate" with many more "at risk of closure." C. 1941–42.

This access crisis has a direct impact on patients: recent data found that more than a quarter of all Alabama births involved inadequate prenatal care and nearly forty percent of pregnant Alabamians struggled to get a desired pregnancy-related appointment. C. 1941–42.

ADPH has identified improving "access to health care" and addressing "health equity barriers," including the "unavailability of services in a community" as priority needs to address this crisis. C. 1942.

B. Midwifery and Out-of-Hospital Birth in Alabama

Plaintiffs are birth centers, their owners, midwives working in the birth centers, and a midwifery association whose members offer or intend to offer midwifery care in birth centers. C. 1942–44; *supra* pp. 14–15. The Plaintiff Birth Centers were founded with the goal of increasing access to midwifery care in Alabama, including birthing care, especially for patients most impacted by the maternal and infant health crisis, based

on evidence that midwife-led care can improve patient outcomes and decrease disparities. C. 1944.

1. Midwifery Philosophy and Training

Midwifery care (or "the midwifery model" or "midwifery model of care") is a patient-centered health care model for low-risk pregnant patients (*i.e.*, those without pre-existing or pregnancy-related conditions that increase the risk of complications) focused on shared decision-making, patient education, and "physiological birth" (*i.e.*, birth with minimal interventions into labor or delivery). C. 1903; C. 1932–33.

Midwifery is practiced by trained midwives with a different skill set, education, and training background than obstetricians. C. 1903; C. 1933. Alabama licenses both certified nurse midwives ("CNMs") and certified professional midwives ("CPMs"). C. 1903; C. 1933. CNMs are registered nurses ("RNs") who have additional training and certification in midwifery and are licensed and regulated by the Alabama Board of Nursing to engage in advanced practice nursing. C. 1903–04; C. 1934–35. CPMs are skilled health care practitioners credentialed by the North American Registry of Midwives ("NARM") and licensed by the Alabama Board of Midwifery after completing an accredited credentialing program

involving both didactic education and hands-on clinical apprenticeship in out-of-hospital birth. C. 1904; C. 1933–34.

In Alabama, CNMs are authorized to provide patient care without direct, on-site supervision, and in both in-hospital and out-of-hospital settings but must maintain a collaborative practice agreement with an Alabama-licensed physician as a condition of licensure. C. 1935; Ala. Admin. Code rr. 610-X-5-.01(5), -.01(15), -.04(1)(b)(3); *see also id.* r. 610-X-5-.20(4). CPMs are authorized to provide independent patient care in out-of-hospital[6] settings and do not require a collaborative agreement to practice. C. 1933, 1935; Ala. Code §§ 34-19-14(b)(2), -16(a). Both CNMs and CPMs provide direct patient care, education, and counseling throughout pregnancy, childbirth, and the postpartum period in the midwifery model of care, with some variations in scope of practice, *see* C. 1903–04 (CPMs can administer medications, while CNMs can administer *or prescribe* medication; CNMs also provide primary and routine reproductive care throughout a patient's life); C. 1933–35 (same).

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[6] In this context, the term "hospital" refers not to facilities that meet the definition in section 22-21-20(1), but to the "commonly understood" meaning of the term, *i.e.*, a general or acute care hospital. *See* Ala. Op. Att'y Gen. No. 2023-012, at 4 (Dec. 15, 2022) [hereinafter "Op. Att'y Gen."]; *cf. also* C. 1902.

Obstetricians are physicians who specialize in caring for pregnant patients, but have different education, training, licensing requirements, and scopes of practice than midwives. C. 1903; C. 1935. For example, obstetricians have completed a medical degree and specialized residency and must be trained to perform surgery and treat abnormality or pathology in pregnancy. C. 1935. The Alabama Board of Medical Examiners oversees the practice of Alabama-licensed physicians, including obstetricians, and, with the Board of Nursing, jointly regulates collaborative practice agreements. C. 1904; C. 1935.

2. Freestanding Birth Centers

An FSBC provides pregnancy, birthing, postpartum, and limited newborn care in a homelike environment to low-risk patients who have been clinically screened and are continuously assessed throughout pregnancy for risk factors that could affect the patient's eligibility for FSBC care. C. 1902; C. 1936. FSBCs are autonomous health care centers and are not attached to or organized as part of a general or specialized hospital or other acute care facility. C. 1902; C. 1936.

Patients seek out-of-hospital birth for a variety of reasons: Some have had a prior traumatic experience in a hospital. C. 1937. For some,

the midwifery model's focus on low-intervention, physiological birth, and home or homelike environments aligns with personal values, beliefs, and health needs. C. 1937. Others wish to avoid interventions common in a hospital setting, such as cesarean section—a major abdominal surgery with short- and long-term health consequences, including for future pregnancies, and which accounts for 35% of all births in Alabama and more than 40% at some hospitals. C. 1937, 1942.

Currently, pregnant Alabamians seeking an out-of-hospital birth have two options: an FSBC or a home birth. C. 1936. Home birth is not an option for everyone, because of, *e.g.*, privacy or space concerns. C. 1937. Therefore, without FSBCs, such patients must travel out of state to give birth or else seek hospital-based care, despite determining with their trusted health care providers that it is not optimal for them given their health needs and individual circumstances. C. 1954–55.

C. "Hospital" Licensing under Alabama Law

The Alabama Legislature authorized ADPH and the State Health Officer to license and regulate, and supervise the licensing and regulation of, facilities defined as "hospitals" under Alabama law, *see* Ala. Code

§§ 22-2-8, 22-21-22; C. 1901. The Legislature defined "hospitals" for these purposes as:

> General and specialized hospitals, including ancillary services; independent clinical laboratories; rehabilitation centers; ambulatory surgical treatment facilities for patients not requiring hospitalization; end stage renal disease treatment and transplant centers, including free-standing hemodialysis units; abortion or reproductive health centers; hospices; health maintenance organizations; and other related health care institutions when such institution is primarily engaged in offering to the public generally, facilities and services for the diagnosis and/or treatment of injury, deformity, disease, surgical or obstetrical care. Also included within the term are long term care facilities such as, but not limited to, skilled nursing facilities, intermediate care facilities, assisted living facilities, and specialty care assisted living facilities rising to the level of intermediate care. The term "hospitals" relates to health care institutions and shall not include the private offices of physicians or dentists, whether in individual, group, professional corporation or professional association practice. This section shall not apply to county or district health departments.

Ala. Code § 22-21-20(1) [hereinafter the "hospital statute," "hospital definition," or "section 22-21-20(1)"].

This definition does not encompass all settings in the state where health care is provided. C. 1938. For example, the Legislature did not

authorize ADPH to license or regulate private physicians' offices, including when they provide prenatal and postpartum care, or even when physicians perform surgical procedures in office settings, such as liposuction and surgeries under general anesthesia. *See* C. 1938; Ala. Admin. Code r. 540-X-10-.01; *see also id.* rr. 540-X-10-.08 to -.09 (procedures under general anesthesia); *id.* r. 540-X-10-.10 (liposuction). Similarly, and importantly, when, in 2017, the Legislature authorized CPMs to independently attend home births, it did not authorize ADPH to license or regulate that care—which involves the same midwifery care and patient populations as FSBCs, C. 1933, 1938, 1949; *infra* p. 36; *see* Childbirth Freedom Act of 2017, Act 2017-383, 2017 Ala. Laws 1235.

In October 2024, ADPH finalized regulations for birth centers, citing its authority under the hospital statute. C. 1902; Ala. Admin. Code rr. 420-5-13-.01 to -.19.[7] Throughout this litigation, Defendant has relied exclusively on the clause of the hospital definition covering "health care institutions 'primarily engaged in offering to the public generally . . . obstetrical care'" as the sole basis of ADPH's purported authority over

[7] To date, the ADPH Regulations have not been enforced against any birth centers. *See* C. 1905; C. 2943; *supra* note 5.

FSBCs. *See* Def. Br. 30 (quoting Ala. Code § 22-21-20(1)); *see also id.* at 9–14; C. 2934. The term "obstetrical care" is not statutorily defined, but the parties stipulated to the medical dictionary definition relied on by the Alabama Attorney General in an advisory opinion addressing section 22-21-20(1): obstetrics is "the *branch of medicine* that concerns management of women during pregnancy, childbirth, and the puerperium." C. 1902 (emphasis added); C. 1939; *accord* Op. Att'y Gen. at 3 (quoting "Obstetrics," *Taber's Cyclopedic Medical Dictionary* (18th ed. 1997)).

D. Plaintiffs and Plaintiff Birth Centers

Plaintiff OFBC is an FSBC in Birmingham, Alabama, founded in June 2022 by Plaintiff Skanes, an Alabama-licensed, board-certified obstetrician and gynecologist ("OB/GYN") and OFBC's Executive Director. C. 1899–1900; C. 1942–43. OFBC first operated between September 2022 and June 2023, prior to the events described *supra* p. 15, and, since January 2024, has been continuously operating pursuant to the injunctions in this case. C. 1905; C. 1942, 1945. OFBC employs licensed midwives, ***not*** obstetricians, to provide all patient care, C. 1905–06; C. 1946, and OFBC patients who require an obstetrician's care are transferred *out* of the birth center to receive that care, C. 1947; *see also*

C. 1905; C. 1946–48. Plaintiff Crawford is a nationally certified, Alabama-licensed CPM, who has provided midwifery care at OFBC since its inception and has more than a decade of experience practicing in home birth and FSBC settings in Alabama and Virginia and training midwifery students as a NARM-registered preceptor. C. 1900; C. 1943, 1945.

Plaintiff ABC is an FSBC in Huntsville, Alabama, founded by Plaintiff Robinson, an Alabama-licensed, board-certified OB/GYN, and ABC's Executive Director. C. 1900; C. 1943. ABC began development in 2020 and, since July 2024, has been continuously operating pursuant to the injunctions in this case. C. 1905; C. 1943, 1945–46. ABC employs licensed midwives, ***not*** obstetricians, to provide all patient care, C. 1905–06; C. 1946, and ABC patients who require an obstetrician's care are transferred *out* of the birth center to receive that care, C 1947; *see also* C. 1906; C. 1946–48. Plaintiff Stone is a nationally certified, Alabama-licensed CPM who provides midwifery care at ABC, where she is Clinical Director, and through her Alabama home birth practice. C. 1900; C. 1943.

Plaintiff ACNM-AL is the Alabama affiliate of the American College of Nurse-Midwives ("ACNM"), the professional association of CNMs that sets national standards for nurse-midwifery education and

practice. C. 1900; C. 1943–44. ACNM-AL provides professional support to and advocacy on behalf of its members, who include all Alabama-based ACNM members (including those dually certified as CNMs and CPMs). C. 1900; C. 1944. Its organizational priorities include addressing the maternal and infant health crisis and expanding access to midwifery care in Alabama, including in out-of-hospital settings. C. 1944. ACNM-AL's membership includes midwives currently employed by FSBCs and those seeking to work in or open FSBCs in Alabama. C. 1944.

OFBC and ABC employ licensed midwives—CPMs or CNMs—to provide midwifery care, including births, prenatal and postpartum care, and neonatal care through six weeks after birth, utilizing the midwifery model of care. C. 1905–06; C. 1946. They also provide patient education and counseling, *e.g.*, on breastfeeding, childbirth preparation, and newborn care, and they facilitate referrals to other practitioners who provide care during pregnancy and postpartum, such as chiropractors, pelvic floor therapists, or mental health providers. C. 1947.

Licensed midwives conduct ***all*** prenatal and postpartum visits and attend ***all*** births in the birth centers, with assistance from RNs, birth assistants, student midwives, doulas, and/or lactation consultants. C.

1905–06; C. 1946. Every birth is attended by staff with training in life support and neonatal resuscitation. C. 1905–06; C. 1946.

OFBC and ABC never offer procedures that are outside the authorized scope of practice of Alabama-licensed midwives, such as surgical deliveries (*i.e.*, cesarean sections), or operative deliveries (*i.e.*, vacuum extraction or forceps-assisted deliveries), which require transfer to obstetrician-led, hospital-based care. C. 1904; C. 1948. They also do not provide interventions that are inconsistent with physiological birth but common in hospitals, such as epidurals, continuous electronic fetal monitoring, or medications to initiate or augment labor; patients requesting or requiring these interventions are transferred to a hospital. C. 1948–49.

All patients at OFBC and ABC are pre-screened for eligibility and receive continuous risk assessment throughout pregnancy to identify any pre-existing or pregnancy-related conditions that could increase the risk of complications. C. 1905–06; C. 1947–48. Patients who are ineligible for birth center care because of such conditions are not cared for in the birth center but instead transferred, depending on the circumstance, to a hospital or an obstetrician—either to Plaintiffs Skanes and Robinson,

through their respective private OB/GYN practices, or to a provider of the patient's choice. C. 1905–06; C. 1946–48. Patients who are otherwise eligible based on low-risk status nonetheless might not be accepted for care unless they agree to certain conditions, *e.g.*, undergoing education to prepare for unmedicated labor and early home discharge, forgoing medicated pain management during labor, and committing to open and honest communication with their midwife. C. 1904–05; C. 1948.

Plaintiffs' risk screening and eligibility procedures are consistent with the midwifery model and the practice of Alabama midwives in other settings, including home births. C. 1949. Plaintiffs Crawford and Stone provide the same midwifery services to patients with the same risk profiles in home birth settings as they do at OFBC and ABC. C. 1949 (citing, *e.g.*, C. 2003 (testimony that birth center and home birth care involve "the same patient screening and eligibility criteria," "the same prenatal care schedule, labor and delivery care, and postpartum care," and the same "healthy, low-risk patients")); C. 2039 (similar).

E. Impact of ADPH's Unauthorized Regulation of Birth Centers

Aside from the legal injury that flows from unlawful government regulation, if Defendant is permitted to exercise unauthorized regulatory

authority over birth centers, *e.g.*, via the ADPH regulations, it would be extremely burdensome, if not impossible, for the Plaintiff Birth Centers to continue operating. C. 1952. This would cause personal, financial, and professional harm to their founders and the midwives who work there and prevent pregnant Alabamians from accessing much-needed care, *see* C. 1952–55.

For example, the ADPH Regulations would restrict CPMs from working to their full scope of practice in FSBCs, impose unnecessary and expensive administrative burdens on CNMs working in FSBCs, and deprive licensed midwives of employment and training opportunities. *See* Ala. Admin. Code r. 420-5-13-.01(2)(b), (d), (f), (w); C. 1902–03; C. 1936, 1946–48, 1951–54. As a result, Alabama's already limited health care work force would be further depleted, and access to much-needed pregnancy-related care further diminished. C. 1939–42, 1954–55.

SUMMARY OF THE ARGUMENT

First, Plaintiffs agree that, as this Court recently resolved, ADPH is immune from suit. Therefore, this action is properly maintained solely against Defendant Harris in his official capacity.

Second, birth centers operating in the midwifery model of care are outside Defendant's regulatory and licensing authority because such birth centers do not meet the definition of a "hospital" under section 22-21-20(1)—in particular, they are not "primarily engaged in offering to the public generally . . . obstetrical care," which is the only part of the definition relied on by Defendant. This is for two independent reasons:

i. Birth centers are not "hospitals" because they do not provide "obstetrical care." Basic canons of statutory construction confirm that "obstetrical care" is not an umbrella term encompassing all forms of pregnancy- and childbirth-related care. Rather, it is a distinct branch of medicine, which, as a matter of law, can only be practiced by licensed physicians, not non-physicians like midwives. The undisputed record confirms that birth centers operating in the midwifery model, like Plaintiffs, exclusively offer midwifery (not obstetrical) care provided by licensed midwives (not physicians).

ii. Birth centers are not "hospitals" because they do not offer care to "the public generally." Basic canons of statutory construction confirm this term refers to facilities like an acute care hospital or emergency department where care is provided to anyone who needs it. By contrast, the undisputed record confirms that birth centers operating in the midwifery model, like Plaintiffs, only accept a subset of eligible, low-risk patients, based on rigorous eligibility criteria and the exercise of provider discretion.

The policy arguments Defendant and amici raise in response are wrong on their own terms, and, moreover, it is black-letter law that this Court cannot override the limits the Legislature set on Defendant's authority by extending the reach of the hospital statute beyond its plain text.

And *third*, the circuit court properly entered a permanent injunction because Plaintiffs demonstrated success on the merits of their AAPA claim, and Plaintiffs satisfied the traditional factors for equitable relief, which Defendant does not contest.

Accordingly, this Court should affirm the entry of summary judgment in Plaintiffs' favor against Defendant Harris.

ARGUMENT

I. ADPH has sovereign immunity, and judgment is proper against Defendant Harris in his official capacity.

Plaintiffs agree that dismissal of ADPH as immune from suit is proper under Section 14 of the Alabama Constitution. *See Ala. Dep't of Conservation & Nat. Res. v. Kellar*, 227 So. 3d 1199, 1200 (Ala. 2017); Def. Br. 28–29.

At the time of filing the original and amended complaints in August 2023 and January 2024, *see* C. 2, 5, no court had resolved whether sovereign immunity barred Plaintiffs from following the AAPA's express requirement that "[t]he agency shall be made a party to [an] action" under section 41-22-10, while *also* suing state officers in their official capacities. *See Ex parte Ala. Med. Cannabis Comm'n*, No. CL-2024-0463, 2024 WL 4401748, at *6 (Ala. Civ. App. Oct. 4, 2024) [hereinafter *"Ex parte AMCC"*] (noting the question had not previously been squarely addressed); *Ala. Dep't of Pub. Health v. Noland Health Servs., Inc.*, 267 So. 3d 873, 876 (Ala. Civ. App. 2018) (Donaldson, J., concurring) (noting unresolved tension between immunity principles and section 41-22-10). As such, to preserve their rights, Plaintiffs named as Defendants both ADPH and Harris, in his official capacity. C. 9, 14–15; C. 997, 1002–04.

However, in October 2024, this Court expressly held that a state agency is not a proper co-defendant under section 41-22-10, *Ex parte AMCC*, 2024 WL 4401748, at *6, and that such actions "may be maintained solely against" agency officials in their official capacities, *id.* at *7; *see also McGilvray v. Perkins*, 407 So. 3d 283, 288 (Ala. 2024) (sovereign immunities do not bar "claims against State officers in their official capacities" that do not "seek the State's funds or to impair the State's property or contractual rights," such as injunctive suits alleging that officials acted "beyond their authority").

This Court should therefore dismiss ADPH and affirm the circuit court's judgment against Defendant Harris.

II. Birth centers operating in the midwifery model of care are not "hospitals" under section 22-21-20(1).

The Legislature limited Defendant's regulatory and licensing authority to only those institutions meeting the definition of a "hospital" under section 22-21-20(1). *See also* Ala. Code § 22-21-21 (charging ADPH with enforcement of standards for the "treatment and care of individuals *in institutions within the purview of this article*" (emphasis added)); C. 1906. The Legislature entrusted regulatory authority over standards of care in facilities *not* meeting that definition to other state bodies, such as

professional licensing boards that oversee the practice of licensed practitioners in *all* settings across the state. For example, the Board of Medical Examiners—*not* ADPH—regulates and sets standards for physicians working in private practice, even when they perform office-based surgery. *See* Ala. Code § 22-21-20(1); *e.g.*, Ala. Admin. Code rr. 540-X-10-.01, -.08 to -.10; *see also* C. 1938. And the Board of Midwifery—*not* ADPH—regulates and sets standards for CPMs providing midwifery care and attending births in patients' homes, *see* Ala. Code §§ 34-19-14, -16; Ala. Admin. Code r. 582-X-3-.03; *see also* C. 1938, the same midwifery and birth care, provided to the same patient populations, as is provided in birth centers, *see* C. 1949; *supra* p. 36.

Here, the parties agree that Defendant has licensing authority over birth centers operating in the midwifery model of care *only if* they satisfy the "hospital" definition, C. 1906; specifically, if they satisfy the definition's catchall clause, which refers in relevant part to "institution[s] primarily engaged in offering to the public generally . . . obstetrical care."[8]

[8] The catchall clause also applies to institutions "primarily engaged in offering to the public generally, facilities and services for the diagnosis and/or treatment of injury, deformity, disease, [or] surgical . . . care," Ala. Code § 22-21-20(1). These other kinds of care are not at issue in this case.

Ala. Code § 22-21-20(1); *see also* Def. Br. 30; C. 2934. This Court must "determine and give effect to the intent of the legislature as manifested in the language of th[is] statute." *Bassie v. Obstetrics & Gynecology Assocs. of Nw. Ala., P.C.*, 828 So. 2d 280, 283 (Ala. 2002) (internal quotation marks and citation omitted).[9]

As set forth below, basic canons of statutory interpretation, along with the undisputed record, dictate that birth centers operating in the midwifery model are not "hospitals" for two independent reasons. First, they do not provide "obstetrical care," which refers to a branch of medicine that is different as a matter of law and fact from the midwifery care that birth centers provide. Second, they do not offer care to "the

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[9] Defendant has waived any argument that ADPH's interpretation is entitled to deference and so this Court need look only to the language of the statute, based on plain meaning and foundational rules of statutory interpretation. *See Ex parte M.P.*, No. SC-2024-0684, 2025 WL 732727, at *13 (Ala. Mar. 7, 2025) ("When an appellant fails to argue an issue in its [initial] brief, that issue is waived." (internal quotation marks and citations omitted)); *accord Devine v. Bank of N.Y. Mellon Corp.*, 296 So. 3d 840, 843 (Ala. 2019). Indeed, as the circuit court correctly concluded, deference is not appropriate in cases such as this where the statutory interpretation question concerns the boundaries of the agency's own jurisdiction. C. 2933 (citing *Fraternal Ord. of Police, Lodge No. 64 v. Pers. Bd. of Jefferson Cnty.*, 103 So. 3d 17 (Ala. 2012)); *accord Ex parte State Health Planning & Dev't Agency*, 855 So. 2d 1098 (Ala. 2002) ("[A]n administrative agency may not expand its own jurisdiction by its interpretation of a statute (or by any other means) . . . .").

public generally," which, for this phrase to have any meaning at all, cannot encompass facilities like birth centers that apply rigorous screening and discretion before accepting patients, rather than taking all comers in need of pregnancy and birthing care.

Defendant's arguments to the contrary, *see* Def. Br. 30–41, and amici's appeal to "public policy," *see* Br. of Amici Curiae Alabama Hospital Association, et al. 3–8 [hereinafter "Hospital Br."],[10] are unavailing and fail to provide a basis to expand Defendant's authority beyond the plain text in order to reach birth centers like Plaintiffs. Basic principles of separation of powers demand that this Court adhere to the plain text and respect the boundaries the Legislature set on Defendant's

[10] Plaintiffs respectfully observe that amicus curiae the Medical Association of the State of Alabama ("MASA") failed to fully disclose its interest in these proceedings. Until October 2024, over a year after this case was filed, MASA was, *as a matter of law*, the entity constituting ADPH. *See* Act No. 2024-247, 2024 Ala. Legis. Serv. § 1 (effective Oct. 1, 2024) (West) (amending sections 22-1-1 and 22-2-4 of the Alabama Code, which previously provided that "[MASA], as constituted under the laws in force or which hereafter may be in force, *is* the State Board of Health," where "State Board of Health" was a synonym for ADPH (emphasis added)). As such, MASA was functionally a defendant throughout most of this case. Even today, it maintains majority control of the state committee through which ADPH operates. *See* Ala. Code §§ 22-1-1, 22-2-4 (as amended Oct. 1, 2024).

authority, which does not encompass licensing and regulation of birth centers providing midwifery care.

Because Plaintiffs are entitled to judgment as a matter of law, *see Archie v. SoFi Lending Corp.*, 399 So. 3d 1067, 1070 (Ala. Civ. App. 2024), this Court should affirm.

A. Birth centers operating in the midwifery model of care, like Plaintiffs, are not offering "obstetrical care."

Birth centers like Plaintiffs that employ midwives to provide midwifery care are not "primarily engaged in offering . . . obstetrical care," Ala. Code § 22-21-20(1), because "obstetrical care" and "midwifery care" are different as a matter of Alabama law. In particular, based on its plain meaning and as used in the Alabama Code, "obstetrical care" refers to *a branch of medicine* that can *only* lawfully be practiced by licensed physicians, not midwives. Defendant's contrary position rests on a single premise: that "obstetrical care" is an umbrella term for all pregnancy- or childbirth-related care, including midwifery. That reading finds no support in plain text or Alabama law. Because it is undisputed that the Plaintiff Birth Centers offer *midwifery* care provided by licensed *midwives*, Defendant's argument fails on both the law and the facts.

1. *Ordinary principles of plain meaning and statutory construction confirm that midwifery care is not "obstetrical care" as a matter of law.*

As with any question of statutory construction, the statute's plain meaning controls. *Bassie*, 828 So. 2d at 283. Because the term "obstetrical care" is not defined by the Legislature, "the plain and ordinary language can be ascertained from a dictionary." *Ex parte Christopher*, 145 So. 3d 60, 64 (Ala. 2013) (internal quotation marks and citation omitted). Here, the parties stipulated to the medical dictionary definition of "obstetrics" as "the branch of medicine that concerns management of women during pregnancy, childbirth, and the puerperium," C. 1902 (quoting "Obstetrics," *Taber's Cyclopedic Medical Dictionary*, *supra*), where "puerperium" means 42 days postpartum, Op. Att'y Gen. at 3.[11] Per this definition, obstetrics refers not to any and all pregnancy care but specifically to the *branch of medicine* involving such care.

Courts must "presume that the Legislature knows the meaning of the words it uses in enacting legislation" and that its choice of words is

[11] The Attorney General adopted the same dictionary definition in an advisory opinion concerning birth centers that predates this action. Op. Att'y Gen. at 3; *see Douglas v. Roper*, 374 So. 3d 652, 671 (Ala. 2022) (such opinions are "persuasive" authority).

not "meaningless." *Reed v. Bd. of Trs. for Ala. State Univ.*, 778 So. 2d 791, 794 (Ala. 2000) (internal quotation marks and citations omitted). Here, the Legislature did not delegate to ADPH licensing and regulatory authority over any institution that offers care for "*pregnancy*." Instead, it used the narrower term "obstetrical care," which refers to a branch of medicine, specifically. Under Alabama law, only a physician, *i.e.*, a doctor of medicine or a doctor of osteopathy, is authorized to "practice medicine." Ala. Code § 34-24-50.1(5), -50.1(6). In fact, it would be a class C felony for a licensed midwife, or any individual or health care provider other than a physician, to "practice[] medicine." *See id.* § 34-24-51 (non-physicians can practice "any *other* branch of the healing arts[] *except medicine*," according to the "scope of [a professional] license" (emphases added)).

Moreover, other parts of the Code affirm that the Legislature understands "obstetrical care" and similar terms to refer to a branch of medicine practiced by physicians, consistent with the stipulated definition.[12] The Legislature repeatedly uses the terms "obstetrical care"

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[12] Amici fault the circuit court for relying on the stipulated definition "[i]nstead of looking to a dictionary," Hospital Br. 9, but the stipulated definition *is* a medical dictionary definition, C. 1902. In any event, amici's proffered definition likewise defines "obstetrics" not as an umbrella term for all pregnancy-related care but specifically as the

or "obstetrics" to refer to care provided by *physicians*, not midwives. *See* Ala. Code §§ 22-6-40 to -42 (referring to programs to improve access to "obstetrical care" and "obstetrical services" in underserved areas by funding "physicians" to provide that care); *id.* § 27-49-2 ("obstetrics and gynecology" is a "specialty" practiced by a "physician"); *see also id.* § 34-19-14(c) (CPMs are not authorized to perform "obstetric procedures"); *cf. id.* §§ 34-24-120(c), -122 (licensed chiropractors are prohibited from practicing "obstetrics" or "osteopathy").

By contrast, even though the Legislature clearly recognizes that midwifery is also pregnancy-related care, the Legislature defines midwifery utilizing wholly different terms—not "obstetrical care" or "medicine." The Legislature defines "midwifery" as practiced by CPMs as "[t]he provision of *primary maternity care* during the antepartum, intrapartum, and postpartum periods," Ala. Code § 34-19-11(3) (emphasis added), and the practice of CNMs as "the performance of *nursing skills* . . . relative to the management of *women's health care*

"*branch of medical science*" involving such care. Hospital Br. at 9 n.4 (emphasis added); *accord* "Obstetrics," *Stedman's Medical Dictionary* 1180 (7th ed. 2014) ("[t]he *specialty of medicine* concerned with the care of women during pregnancy, parturition, and the puerperium" (emphasis added)).

focusing on pregnancy, childbirth, the postpartum period, [and] care of the newborn," *id.* § 34-21-81(2)(b) (emphases added). *See also id.* § 34-19-18(b) (CPM license does not "authoriz[e] a licensed midwife to practice medicine"); *infra* note 13 & pp. 57–58 (CNMs practice nursing, not medicine).

Certainly, if the Legislature intended to define midwifery care in reference to, or as a subset of, obstetrical care, and therefore to ensure that facilities providing midwifery care qualify as "hospitals" under section 22-21-20(1), it could easily have said as much. Instead, the Legislature defined midwifery care at length, in two different statutes, enacted at two different times post-dating the hospital definition,[13] without ever invoking the terms "obstetrical care" or "medicine" to describe the care midwives provide. The weight of this evidence cannot

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[13] *See* Act No. 530, § 1, 1949 Ala. Laws 835, 835 (the hospital statute as originally enacted, including the "primarily engaged in offering . . . obstetrical care" clause); Childbirth Freedom Act, § 1, 2017 Ala. Laws 1235 (authorizing practice of CPMs and, *inter alia*, defining "midwifery" as "primary maternity care"); Act No. 95-263, § 2, 1995 Ala. Laws 464, 465 (defining practice of nurse-midwifery as "performance of nursing skills" relative to "women's health care"); *see also* Act No. 499, §§ 1, 5, 1976 Ala. Laws 624, 624–26 (older version of CNM statute also defining "practice of nurse midwifery" without using the term "obstetrical care" and stating that nurse-midwifery license "shall not confer . . . the right to practice medicine").

be brushed aside. Where, as here, the Legislature "has used one term in one place, and a materially different term in another, the presumption is that the different term denotes a different idea[.]" *Sw. Airlines Co. v. Saxon*, 596 U.S. 450, 458 (2022) (quoting Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 170 (2012)); *accord* 2A Norman J. Singer, *Sutherland Statutory Construction* § 46:6 (7th ed. 2010) ("Different words used in the same, or [a] similar, statute are assigned different meanings whenever possible."). In asking this Court to construe "obstetrical care" as an umbrella term encompassing all pregnancy-related care (including midwifery), against all evidence to the contrary, Defendant and amici ignore this foundational principle of statutory construction, and their statutory arguments must fail.

For the first time on appeal, Defendant argues that a reference to *prohibited* "obstetric procedures" in the CPM statute indicates, *sub silentio*, that everything a CPM *is* authorized to do must therefore be "obstetrical care." *See* Def. Br. 34–35 (citing Ala. Code § 34-19-14(c)); *see also* Hospital Br. 11. This proves too much. *See, e.g.*, Linda D. Jellum, *Mastering Statutory Interpretation* 104 (2008) ("Legal drafters often include redundant language on purpose to cover any unforeseen gaps[.]").

It would strain basic canons of statutory construction to read this isolated provision to negate, implicitly, all legislative evidence to the contrary. As set forth *supra*, the Alabama Code is replete with examples that midwifery and obstetrical care are "materially different term[s]" that denote "different idea[s]." *Sw. Airlines Co.*, 596 U.S. at 458 (quoting Scalia & Garner, *supra*, at 170). Indeed, when *explicitly* defining and setting standards for what midwives *are* authorized to do, the Legislature never uses the term "obstetrical care" or anything similar. *See* Ala. Code § 34-19-11(3) ("midwifery" definition as "primary maternity care"); *see also id.* § 34-19-14(b)(1) (requiring standards for CPM practice to be "consistent with" publications from national *midwifery* organizations).

Amici's references to various statutes recognizing that midwives provide pregnancy-related and early newborn care fare no better. *See* Hospital Br. 12 (citing Ala. Code §§ 22-20-2 to -3 (referring to non-physicians, including nurses and midwives, who attend childbirth and provide immediate newborn care)). That midwives provide such care is beyond dispute, but nothing in these statutes indicates that the Legislature considers such care to be "obstetrical care." Rather, all these statutes show are yet more examples of the Legislature discussing the

pregnancy-related care that midwives provide *without calling it "obstetrical care*."[14]

In sum, the stipulated dictionary definition and references across the Alabama Code make clear that midwifery care is legally distinct from "obstetrical care" and that midwives cannot provide "obstetrical care" as a matter of law.

2. *The undisputed record confirms that birth centers operating in the midwifery model of care, like Plaintiffs, are not providing "obstetrical care" as a matter of fact.*

The undisputed record in this case further underscores the material difference between obstetrical and midwifery care reflected in the Alabama Code: obstetrics is a surgical specialty, and obstetricians must be trained to treat abnormality or pathology in pregnancy, C. 1935; midwifery, by contrast, is a holistic model of care focused on healthy, low-risk pregnancies and physiological birth with minimal or no technological interventions into labor and delivery, C. 1932–33. Obstetricians are

[14] In fact, in another statute cited by amici, Hosp. Br. 8 n.3, the Legislature uses still another, *different* term—"perinatal care"—when referring broadly to pregnancy-related care delivered across a range of hospital and out-patient settings and without restriction to a particular kind of licensed practitioner. *See* Ala. Code §§ 22-12A-2 to -3.

physicians who have obtained medical degrees, and they have different education and training requirements, scopes of practice, and credentialing and licensing bodies and requirements than midwives. C. 1904; C. 1933–35.

Alabama-licensed midwives working in birth centers *never* perform surgical or instrument-assisted deliveries—which are part of the practice of obstetrics but outside the scope of practice of Alabama-licensed midwives. C. 1948–49; *see* C. 1942. And midwives transfer patients to an obstetrician if a patient develops a high-risk condition or complication that may require obstetrical interventions outside the scope of midwifery. *See* C. 1947–49. Thus, in focus, education, training, and scope of practice, obstetrical care and midwifery care are distinct fields of practice, consistent with their treatment as different under Alabama law.

The record, including the joint stipulations, affirms that the Plaintiff Birth Centers provide *midwifery* care: Plaintiffs provide "midwifery services," C. 1900, 1905–06, "utilize[e] [the] midwifery model of care," C. 1903, and employ midwives to "conduct *all* prenatal and postpartum visits and attend births," C. 1905 (emphasis added); *see also* C. 1906. Unable to escape the force of these concessions, Defendant and

amici make a range of arguments that attempt either to muddy the facts or to distort their significance, in order to try to cast what birth centers do as "obstetrical care." These arguments fail.

First, Defendant repeatedly focuses on evidence that birth centers provide pregnancy, birthing, and postpartum care. *E.g.*, Def. Br. 30–32, 35. This is true and legally irrelevant. The determinative question is not, as Defendant misleadingly suggests, whether birth centers offer "*health care* to women throughout all stages of pregnancy," Def. Br. 31 (emphasis added), or utilize a "*healthcare model* that manages and offers care to women throughout pregnancy and childbirth," *id.* at 35 (emphasis added).[15] Rather, per the definition Defendant stipulated to and as reflected in Alabama law, the relevant question is whether birth centers are engaged in "*the branch of medicine*" involving these things.[16]

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[15] *See also id.* at 32 (claiming midwifery care "*encompasses* the management of women during pregnancy, childbirth, and the puerperium" and "is undeniably *linked* with the provision of obstetrical care," but not that it constitutes a branch of medicine (emphases added)).

[16] The stipulated definition is not, as Defendant's brief suggests, that "[o]bstetrics *includes* the 'branch of medicine'" involving pregnancy care, Def. Br. 30 (emphasis added), but that "[o]bstetrics *is* '[t]he branch of medicine that concerns management of women during pregnancy, childbirth, and the puerperium.'" Op. Att'y Gen. at 3 (emphasis added) (quoting *Taber's Medical Dictionary*, *supra*); C. 1902 (stipulating to this definition).

Defendant does not—and cannot—claim that they are. This is a distinction *with* a difference. *See supra* Argument Section II.A.1.

Second, Defendant and amici insist that, just because in practice there is some overlap in the specific services midwives and obstetricians provide—such as "administer[ing] medications and order[ing] laboratory tests," Def. Br. 35—that means midwives must be providing "obstetrical care." *See also* Hospital Br. 13–14. Such reasoning collapses under any scrutiny.

There are many examples in health care where different practitioners with different scopes of practice nonetheless provide the same service or treat the same condition, including when those practitioners include physicians and non-physicians; that does not mean the kind of care they provide is categorically the same. For example, both obstetricians and ultrasound technicians perform prenatal ultrasounds; does that mean an ultrasound technician is practicing "obstetrics" as opposed to sonography? Psychiatrists, psychologists, and social workers all engage in talk therapy; are social workers therefore providing "psychiatric care" when they counsel patients? An emergency medical technician ("EMT") is trained to use a defibrillator, and so is a

cardiologist; does that make it "cardiology" when an EMT shocks a patient's heart? These terms of art simply cannot be so loosely interchanged. That these practitioners may treat the same condition (mental health, heart failure) or perform the same service (ultrasound, talk therapy) does not negate that they practice legally and factually distinct disciplines. Nor should this Court stretch the meaning of "obstetrical care" to reach midwifery (or vice versa), against the overwhelming evidence that the Legislature does not consider them to mean the same thing, *see supra* Argument Section II.A.1, just because midwives and obstetricians both care for pregnant patients and, at times, provide similar services.

Contrary to Defendant's assertion, *Tucker v. State Department of Public Health*, *see* Def. Br. 34; Hospital Br. 16, does not say otherwise. *Tucker* concerned whether a private physician's office that indisputably provided abortion care could lawfully be categorized as an "abortion or reproductive health center," and therefore subject to ADPH licensure, based on the volume of abortions provided. 650 So. 2d 910, 911–13 (Ala. Civ. App. 1994). Nothing in that case supports Defendant's underlying argument that the training, experience, and licensure of a practitioner is

wholly irrelevant in determining the category of care they are providing. If anything, *Tucker* undermines Defendant's claim that FSBCs must be providing obstetrical care simply because midwives do some of the same things as obstetricians. In *Tucker*, the individual procedure was not determinative; instead, as ADPH maintained and the Court recognized, the exact same abortion care could be provided in a physician's office *without* requiring a license, but in other contexts *would* require a license as an abortion or reproductive health center based on *other facts* about how the facility operated. *See id.* at 913–14.

Third, neither the fact that CNMs maintain collaborative practice agreements ("CPAs") with physicians as a condition of licensure, nor the fact that the Plaintiff Birth Centers are owned by OB/GYNs somehow transforms the midwifery care they provide into the "practice of medicine" or "obstetrical care." *See* Hospital Br. 15–16. As a matter of law, the practice of a CNM pursuant to a CPA is "the performance of nursing skills," Ala. Code § 34-21-81(2)(b), *not* the "practice of medicine," *id.* §§ 34-24-50.1(5), -50.1(6), -51 (practice of "medicine" by *anyone* other than a licensed physician is a felony). And CPAs do not require "direct, on-site supervision" of CNMs by physicians, Ala. Admin. Code r. 610-X-

5-.01(5); *accord id.* r. 610-X-5-.01(15) (authorizing CNM practice at "remote practice sites without collaborating physicians present").

In addition, the fact that the Plaintiff Birth Centers have physicians as owners and executive directors, C. 1943, does not mean that the physicians provide patient care there. In fact, the undisputed record shows otherwise. *See* C. 1905–06 (Plaintiffs employ midwives to "conduct all prenatal and postpartum visits" and "attend births" in the birth center); C. 1947 (if birth center patients need an obstetrician's care, they "are not cared for in the birth centers but instead transferred" to an obstetrician's separate practice or a hospital); *see also supra* pp. 32–36.[17]

[17] It is important to note that the circuit court's ruling was limited to birth centers that "operat[e] in the midwifery model of care," like the Plaintiffs do. C. 2942–43. If an out-of-hospital facility opened in Alabama and focused on employing obstetricians to provide services such as cesarean sections that are clearly obstetrical in nature—a model of care that exists in Florida, for example, *see* Fla. Stat. § 383.302(1) (2024)—that facility would not be operating in the midwifery model of care and the circuit court's ruling would not prevent ADPH from treating that facility as a provider of "obstetrical care" under the hospital statute. Moreover, the Legislature clearly used the phrase "*primarily* engaged in offering . . . obstetrical care," Ala. Code § 22-21-20(1) (emphasis added), thus negating amici's suggestion, *see* Hospital Br. 15–16, that a single or rare instance of an obstetrician being involved in any clinical care at a birth center would instantaneously convert the facility into a "hospital" for licensing purposes.

Finally, lurking underneath many of Defendant's and amici's arguments is the suggestion that it is somehow unreasonable for the licensing status of a particular facility to turn on fact-specific questions, like who provides care and what their scope of practice is. *See, e.g.*, Def. Br. 34; Hospital Br. 16. But that is not so. As even the Attorney General has recognized, whether ADPH has licensing authority often turns on factual questions. *See* Op. Att'y Gen. at 3 (whether a facility provides "obstetrical care" is a "factual determination"). As one example, prior to the prohibition of virtually all abortion care in Alabama, whether a doctor's office required a license as an "abortion or reproductive health care facility" turned on *the number* of abortions provided per month or per year and/or whether it advertised abortion services by some public means, Ala. Admin. Code r. 420-5-1-.01(e)—plainly factual questions. Here, too, an examination of the facts is both appropriate and determinative: birth centers like the Plaintiffs that operate in the *midwifery* model and exclusively employ *midwives* to provide *midwifery* care do not fall within the legal definition of a "hospital."

Moreover, treating the training, experience, and legal scope of practice of the individual providing care as categorically irrelevant, as

Defendant and amici insist, would lead to absurd results—for example, a crisis pregnancy center where nurses or other non-physicians offer ultrasounds to confirm and date pregnancy would, according to Defendant's and amici's logic, be engaged in offering obstetrical care under the hospital definition, even if there were no physicians on staff. Nothing in the hospital statute supports an argument that the Legislature intended to ignore such plainly relevant factual differences.

In sum, because the midwifery care birth centers provide is *not* obstetrical care as a matter of fact and a matter of law, Defendant lacks statutory authority to license or regulate them as "hospitals."

B. Birth centers operating in the midwifery model of care, like Plaintiffs, do not offer care to "the public generally."

Plaintiffs are also entitled to summary judgment for the independent reason that they do not offer care to "the public generally," Ala. Code § 22-21-20(1), based on the undisputed facts and the plain meaning of that term. Defendant's contrary argument ignores the facts and renders the statutory language meaningless.

As the record confirms, far from offering their care to the public writ large, Plaintiffs are akin to private medical practices or home birth

practices—both outside Defendant's purview—where providers exercise discretion in taking on new patients, *see* C. 1936, 1948–49; *cf.* Ala. Code § 20-21-20(1). As explained *supra* pp. 28, 35–36, it is undisputed that FSBCs like Plaintiffs rigorously and continuously screen patients and exercise discretion to ensure both patient eligibility and suitability for FSBC care. This is in stark contrast to facilities like acute care hospitals or freestanding emergency departments, which by their nature offer services to members of the community at large and are legally obligated to provide care to *any* pregnant patient who presents at the emergency department in labor. Ala. Admin. Code r. 420-5-9-.01(2)(c) (freestanding emergency departments are "held out to the public as a facility that receives patients without requiring an appointment"); 42 U.S.C. § 1395dd(b); *accord* Hospital Br. 5.[18]

[18] Because these are clear examples of facilities that offer services to "the public generally," Defendant is wrong that Plaintiffs' reading "would render almost no facility open to the public generally." Def. Br. 38. Additional examples are also possible: for example, a freestanding labor-and-delivery unit that offers the same obstetrical care available in a hospital, like cesarean sections, and that is open to the general public without an appointment. If it existed, such a facility would be covered by the catchall clause. *See* 2B Norman J. Singer, *Sutherland Statutory Construction* § 49:1 (7th ed. 2010) (statutes "are often couched in general terms purposefully designed to embrace circumstances unforeseen at the time of enactment").

Plaintiffs thus do not offer care to "the public generally" under the plain meaning of that term. The Alabama Supreme Court has repeatedly treated the term "the public generally" as legally distinct from individual members of the public, or even from specific classes or sub-categories of the public. *See, e.g.*, *Parker Bldg. Servs. Co., Inc. v. Lightsey ex rel. Lightsey*, 925 So. 2d 927, 931 (Ala. 2005) (distinguishing statutes enacted to "protect the public generally" from statutes that "delineate a specific class of persons . . . distinguishable from the public"); *Funliner of Ala., L.L.C. v. Pickard*, 873 So. 2d 198, 209 (Ala. 2003) (holding plaintiffs in public nuisance class action must show a "group injury" distinct from injury to "the public generally"); *Williams v. Ala. Fuel & Iron Co.*, 102 So. 136, 139 (Ala. 1924) (holding statute was enacted for protection of class of "owners, operators, and employés [sic] of coal mines . . . as distinguished from the public generally"). Certainly, in each of these cases, the specific classes of people the Court determined were *legally* distinct from "the public generally" were nevertheless members of the public. But, as these precedents illustrate, offering services to "the public generally" is distinct as a matter of law from offering services to certain classes or sub-categories of the public. Here, only a strictly defined class

of low-risk patients are eligible for birth center care, and only a subset of this class is ultimately accepted into care based on additional conditions; even then, a member of the class will continue as a patient only if she remains low-risk throughout pregnancy. *See supra* pp. 28, 35–36. The foregoing cases establish that this limited group is *not* "the public generally."[19]

Defendant attempts to evade this conclusion by citing a dictionary definition of "generally" to argue that all the catchall clause requires is for a facility to "typically" or "usually" offer care to the public. Def. Br. 39. But "[i]n interpreting statutory language, a court does not look at one word . . . in isolation." *Ala. Dep't of Pub. Health v. TSTL Holdings, LLC*, No. CL-2024-0604, 2025 WL 1198441, at *5 (Ala. Civ. App. Apr. 25, 2025) (internal quotation marks and citation omitted). By slicing the term "the public generally" in half, Defendant distorts its meaning and ignores

[19] For this reason, Defendant's claim that Plaintiffs "readily admit" "any patient" in this limited class, Def. Br. 36, puts the cart before the horse, because more is required to offer care to "the public generally." Moreover, it is not even true that anyone meeting eligibility criteria on paper "can and will be served" by Plaintiffs, *id.*; as the undisputed facts confirm, the ultimate decision is discretionary, *see* C. 1904–05 (patients who "*might* otherwise be eligible" must satisfy additional requirements before being accepted into care (emphasis added)); C. 1948.

precedents discussed *supra* that distinguish "the public generally" from a subset or discrete class of persons.

Moreover, if, as Defendant insists, all that is required to offer care to "the public generally" is to serve members of the public who meet certain requirements, Def. Br. 38–39, it is difficult to envision a health care institution that would *not* be serving "the public generally." That reading renders the phrase meaningless, in defiance of the rule that statutes should be interpreted so that "every word, sentence, or provision . . . [is] intended for some useful purpose, [and] has some force and effect." *City of Montgomery v. Town of Pike Rd.*, 35 So. 3d 575, 584 (Ala. 2009) (internal quotation marks and citation omitted); *see also* 2A *Sutherland Statutory Construction*, *supra*, § 46:6 ("[c]ourts construe [statutes] . . . so that no part is inoperative or superfluous"). The conclusion that birth centers operating in the midwifery model do *not* offer care to "the public generally" is the only reading that would give these words independent "force and effect," *City of Montgomery*, 35 So. 3d at 584 (internal quotation marks and citation omitted).

That the broader hospital definition explicitly identifies *other* facilities, like transplant centers or ambulatory surgical treatment

facilities ("ASFs"), that provide more limited services or treat limited classes of individuals, *see* Def. Br. 37, is irrelevant. The "public generally" requirement appears *only* in the catchall clause, which the parties agree is the only part of the hospital statute at issue in this case, *see, e.g.*, Def. Br. 30; C. 2934. These other facilities constitute "hospitals" under the law because the Legislature chose to *explicitly name them as such*, regardless of whether or not they serve the public generally. *See* 2A *Sutherland Statutory Construction*, *supra*, § 46:6 ("Where a legislature includes particular language in one section of a statute but omits it from another[,] . . . it generally acts intentionally and purposefully in the disparate inclusion . . . ."); *see also* C. 2940.[20]

[20] In fact, the Legislature added "surgical" care to the catchall clause and "ambulatory surgical treatment facilities for patients not requiring hospitalization" as a standalone category in the hospital definition at *the same time*, Act No. 79-798, § 1, 1979 Ala. Laws 1461, 1461. That would have been unnecessary if the Legislature believed that ASFs, which provide limited services to patients who require "the recommendation of a physician" to be admitted, Ala. Admin. Code r. 420-5-2-.01(2)(*l*), offered surgical care to "the public generally" and would therefore be covered by the catchall clause. *See Weathers v. City of Oxford*, 895 So. 2d 305, 309 (Ala. Civ. App. 2004) (statutes should be read so that the "Legislature intended a just and reasonable construction" and no provision "has no practical meaning").

Finally, Defendant cannot derive support from section 22-21-21's statement of legislative purpose either. Section 22-21-21 does not merely say that the purpose of hospital licensing is to "provid[e] for the development, establishment and enforcement of standards for the treatment and care of individuals" *full stop*, as Defendant's selective quotation suggests. *See* Def. Br. 40; *see also* Hospital Br. 5. Instead, it says the purpose is to provide such standards for the "treatment and care of individuals *in institutions within the purview of this article*," Ala. Code § 22-21-21 (emphasis added)—that is, those in institutions meeting the hospital definition in section 22-21-20(1). A legislative purpose that is explicitly cabined by reference to a defined list of covered institutions provides no basis for giving that list a more expansive reading than its plain terms support.

Parker Building Services, *see* Def. Br. 40, is instructive. There, the Court interpreted a city ordinance to have a purpose of protecting the public generally because it referred to a "remedial" purpose of protecting "public safety, health, and general welfare," and *did not* "identify [a] group" or "subset of persons" to which it was targeted. 925 So. 2d at 931–32. The critical difference here is that the Legislature *did* identify a

discrete class of persons that hospital licensing was meant to protect: "individuals in institutions within the purview of this article." Ala. Code § 22-21-21; *see also Parker Bldg. Servs.*, 925 So. 2d at 932 (distinguishing the public generally from the "subset of persons inside a building"). Thus, section 22-21-21 directs itself towards a specific class of covered individuals in specified settings, and *not* more broadly than that.[21]

For the reasons set forth above, Plaintiffs are entitled to summary judgment for this additional reason, as well.

C. Policy arguments neither authorize nor justify departing from section 22-21-20(1)'s plain text, under which birth centers operating in the midwifery model of care, like Plaintiffs, are not "hospitals."

Defendant and amici raise additional arguments in an attempt to persuade this Court that their position is good *policy*. *See, e.g.*, Def. Br. 30–31, 38, 40–41; Hospital Br. 2–8. Not only do these arguments lack merit, as explained below, but they provide no basis to override the Legislature's judgment. Courts "are not at liberty to ignore or adjust the

[21] Even if the statute were ambiguous, *see* Def. Br. 40–41, which it is not, *Norfolk South Railway Co. v. Johnson* supports Plaintiffs' interpretation of the hospital definition because the "results that would flow," 740 So. 2d 392, 396 (Ala. 1999), from reading "the public generally" as Defendant proposes would give the term no meaning, *see supra* p. 64.

plain meaning of the statute," based on purported "tension with perceived public policy." *Ex parte Hubbard*, 321 So. 3d 70, 90 (Ala. 2020). Where, as here, the Legislature has expressly limited ADPH's authority to only those facilities meeting the hospital definition, and, for the foregoing reasons, birth centers operating in the midwifery model do not fall with the plain terms of that definition, the Legislature's choices as "manifested in the language of the statute" are "conclusive." *Bassie*, 828 So. 2d at 283.

But Defendant and amici's arguments also fail on their own terms. First and foremost, the undisputed record demonstrates that the greatest danger to the health of mothers and babies in Alabama is a lack of *access* to any care whatsoever. Defendant admits that Alabama faces an "urgent maternal and infant health crisis," C. 1939; that "inadequate access to pregnancy-related care" is "a significant driver" of that crisis, "increasing the risk of preterm birth and low birthweight," C. 1941; and that improving "access to health care" and reducing "health equity barriers" are priorities for the state, C. 1942; *see also* C. 1939–42. Birth centers *address* these problems by offering proven safe options to expand access to care in a state that is facing rampant hospital closures and widespread

care deserts. *See* C. 942 (circuit court concluding that birth centers "would help address the dire needs of their communities," especially for "the patient populations most at risk of adverse outcomes and harm"); C. 1944, 1950–51 (identifying benefits of birth center care).

Second, there is no truth to the claim that birth centers—including the Plaintiffs, who have been open and operating safely for more than a year, C. 1945–46—will be devoid of "oversight and uniformity of standards of care and safety," if the circuit court decision is affirmed. Hospital Br. 6. As explained *supra* pp. 30–31, 41–42, ADPH is not the only state entity that the Legislature entrusted with authority to oversee and set standards for the provision of health care. For example, amici Board of Medical Examiners ("ALBME") and Board of Nursing ("ALBON") themselves have responsibility for setting standards for physicians and nurses,[22] including in settings that lack ADPH licensure or regulation, *see* C. 1938; Ala. Admin. Code r. 540-X-10-.13. Surely amici

[22] *See, e.g.*, Ala. Code §§ 34-24-53(a), -53.1(a) (ALBME rulemaking authority over practice of medicine or osteopathy); *id.* § 34-21-87 (ALBON and ALBME joint committee authority to "recommend model practice protocols" for nurse practitioners and CNMs practicing under CPAs); Ala. Admin. Code rr. 610-X-5-.10, 610-X-5-.21, 610-X-6-.01 *et seq.*, 610-X-7-.01 *et seq.*, 610-X-9-.01 *et seq.* (ALBON rules setting standards of practice for nursing and advanced practice nursing).

do not believe that, when licensed doctors and nurses perform or assist in office-based surgeries, "the health and well-being of the public is left unprotected," Hospital Br. 7, simply because amici are in charge of standards and oversight, rather than ADPH.[23]

The Plaintiff Birth Centers are no different: If the circuit court judgment is affirmed, professional boards including ALBON and the Board of Midwifery will continue to have responsibility for ensuring that CNMs and CPMs practicing in birth centers comply with standards of care and safety required for their professions.[24] If amici take issue with the decision to entrust oversight of settings like birth centers to the professional licensing boards instead of ADPH, "any remedy lies with the legislature, not the courts." *Hubbard*, 321 So. 3d at 90.

Further, the contention that ADPH regulation is necessary to address "public expectations" for birth centers, and the "obvious

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[23] In fact, ADPH Medical Director, Dr. Karen Landers, testified at an earlier stage of these proceedings that ADPH had no "safety concerns" about such surgeries, "even though those entities are not regulated by ADPH, because physicians remain subject to oversight by [ALBME]." C. 1938 (quoting C. 935).

[24] ALBME also has oversight authority related to CPAs pursuant to which CNMs would practice in birth centers. *See* Ala. Admin. Code r. 540-X-8-.01 *et seq*.

differences between a home birth and birth in a clinical facility," Hospital Br. 6, is contradicted by the undisputed record. The midwifery care provided in patients' homes and the midwifery care provided in a birth center's "homelike environment," C. 1902; C. 1936, involve the exact same services, screening and transfer procedures, and low-risk patient populations, C. 1949; *see supra* p. 36. Even if a particular individual were to approach a birth center with an expectation of more hospital-like than homelike features, that patient would quickly be disabused of that misconception upon meeting with a midwife and being oriented to the birth center's philosophy of care, offered services, and eligibility procedures—indeed, clear communication about such factors is central to the midwifery model. *See, e.g.*, C. 1932, 1948 (emphasizing "open and trusting relationship between the midwife and their patient," "honest[] communica[tion], and "patient education," including to prepare patients for a birth center birth); C. 1903–05 (similar).

Third, there is no legal basis for arguing that, notwithstanding the plain text of the hospital definition, ADPH has some sort of roving authority to license and regulate birth centers. *See, e.g.*, Hospital Br. 4–5. Regardless of any other powers delegated to ADPH, with respect to

licensing authority specifically, the Legislature expressly cabined ADPH's authority to a defined set of facilities. As explained *supra* p. 66, Defendant and amici misquote the relevant statute, omitting the crucial portion that constrains ADPH's authority to only those "*institutions within the purview of this article*," Ala. Code § 22-21-21 (emphasis added), *i.e.*, those defined as "hospitals." To suggest that the Legislature granted ADPH authority over *all* institutions, not merely those defined as hospitals, is false. Indeed, it is undeniable that the institutions within ADPH's statutory purview, *see* Ala. Code § 22-21-20(1), do not comprise *all* settings in the state where health care is delivered, or even where all pregnancy-related or birthing care occurs. As discussed *supra* pp. 30–31, 41–42, doctors provide both routine care, including prenatal and postpartum care, and *surgeries under general anesthesia* in private practices that are exempt from ADPH regulation, and, for the better part of a decade, midwives have been providing midwifery care, including birthing care, in patient homes without ADPH oversight or regulation.

Legislative history confirms these limits. Notwithstanding the catchall clause at issue in this case, which has been largely unchanged

since 1949,[25] each time the Legislature elected to expand ADPH's licensing authority, the Legislature amended the statutory definition to add new, explicit categories of covered facilities. *See* Act No. 122, § 2, 1962 Ala. Laws 157, 157 ("domiciliary institutions, homes for the aged, intermediate institutions, and related institutions"); Act No. 140, § 1, 1975 Ala. Laws 382, 383 ("independent clinical laboratories," "health maintenance organizations"); Act No. 79-798, § 1, 1979 Ala. Laws 1461, 1461 ("general and specialized hospitals, including ancillary services," "rehabilitation centers," "ambulatory surgical treatment facilities," "end stage renal disease treatment and transplant centers," "abortion or reproductive health centers"); Act No. 91-548, § 1, 1991 Ala. Laws 1010, 1010 ("hospices"); Act No. 2001-1058, § 1, 2011 Ala. Laws 1044, 1045 ("specialty care assisted living facilities"). The Legislature could do the same thing to add freestanding birth centers to the hospital definition if it wanted to, but it has not.[26]

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[25] As originally enacted, the catchall clause applied to institutions "primarily engaged in offering to the public generally facilities for the diagnosis and treatment of injury, deformity, disease or obstetrical care." Act No. 530, § 1, 1949 Ala. Laws 835, 835. In 1979, the Legislature added "surgical" care. *Supra* note 20.

[26] For example, the Kentucky and Michigan Legislatures added FSBCs to their own licensing laws just this year. *See* Ky. Rev. Stat. Ann.

Accordingly, where it is apparent from the plain text of the hospital statute and all other evidence of legislative intent that Defendant lacks authority to license and regulate birth centers operating in the midwifery model of care as "hospitals," there is neither reason nor authority to disregard the limits set by the Legislature. This Court should affirm the circuit court's ruling.

III. The circuit court correctly held that Plaintiffs are entitled to a permanent injunction.

The circuit court correctly granted a permanent injunction, in addition to declaratory relief. C. 2941–43. First, where, as here, Defendant has exceeded his statutory authority through an invalid rule, the AAPA authorizes an injunction to prevent Defendant from "invok[ing] . . . for any purpose" that invalid rule. *Keith v. LeFleur*, 400 So. 3d 608, 620 (Ala. Civ. App. 2023); *see* Ala. Code § 41-22-10.

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§ 216B.198 (West) (effective June 27, 2025) (directing Kentucky Cabinet for Health and Family Services to "establish licensure standards for freestanding birth centers"); Mich. Comp. Laws Ann. § 333.20711 (West) (effective Apr. 2, 2025) (requiring FSBC licensure by Michigan Department of Licensing and Regulatory Affairs). Indeed, of the states that require birth center licensure at all, most do so via a similarly explicit statutory mandate. *See, e.g.*, Colo. Rev. Stat. Ann. § 25-1.5-103 (West 2024); Del. Code Ann. tit. 16, § 122 (West 2024); Tenn. Code Ann. § 68-11-202 (West 2024); Tex. Health & Safety Code Ann. § 244.003 (West 1989). That is not the case here.

Second, Plaintiffs also satisfied the traditional equitable factors for injunctive relief: (i) "success on the merits," (ii) "a substantial threat of irreparable injury," (iii) that "outweighs the harm the injunction may cause" the defendant, and (iv) no "disserv[ice] [to] the public interest." *Tipp v. JPMC Specialty Mortg., LLC*, 367 So. 3d 357, 363 (Ala. 2021). Defendant only contests the merits factor, Def. Br. 41–42, which, for the reasons explained *supra* Argument Section II, the circuit court correctly decided in Plaintiffs' favor. Defendant thereby concedes the remaining factors. *See Devine*, 296 So. 3d at 843 ("any issue not argued" in opening brief "is waived").

But even were the other factors not waived, the record thoroughly demonstrates that Plaintiffs satisfied them as well. First, Plaintiffs established a clear threat of irreparable injury. As just one example, the undisputed record establishes that Plaintiffs Skanes and Robinson would suffer profound and irreparable personal, financial, and professional harm if Defendant is permitted to exceed his statutory authority in this respect, C. 1952; C. 2942, even facing an "existential threat to [their] businesses," C. 2942 (citing *Ala. Educ. Ass'n v. Bd. of Trs. of Univ. of Ala.*, 374 So. 2d 258, 262 (Ala. 1979) (recognizing such harm as irreparable));

see also C. 1952–54 (detailing irreparable harm to midwife Plaintiffs, including disruption to patient relationships, denial of professional opportunities, and restrictions on scope of practice); *supra* pp. 36–37.

The final two factors also favor injunctive relief: Defendant suffers no harm from an injunction that simply ensures adherence to the limits of his authority, *see City of Ctr. Point v. Atlas Rental Prop.*, 371 So. 3d 856, 862 (Ala. 2022); and the public interest will benefit from birth centers offering much-needed pregnancy care and thus "help[ing] [to] address the dire needs of their communities," C. 942, in the midst of a statewide crisis for access to maternal and infant health care, C. 1939–42, 1954–55.

CONCLUSION

For the forgoing reasons, the Court should affirm the circuit court's grant of summary judgment, a declaratory judgment, and a permanent injunction to Plaintiffs as against Defendant Harris, and remand to the circuit court to dismiss ADPH as a defendant.

Respectfully submitted this 19th day of August,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this document complies with the font and word limitations set forth in Rules 28(j)(1), 32(a)(7), and 32(d) of the Alabama Rules of Appellate Procedure in that the entire document is typed in Century Schoolbook font using 14-point type and the pertinent parts of this document under Rule 28(j)(1) contain a total of 13,066 words, according to the word-count function of Microsoft Word.

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CERTIFICATE OF SERVICE

I certify that on this 19th day of August, 2025, I electronically filed a true and correct copy of the foregoing with the Clerk of Court using the C-Track E-Filing system, and served a copy via email or U.S. Mail on the following counsel of record:

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Addendum of Statutes

(Ala. R. App. P. 28(h))

Ala.Code 1975 § 22-21-20

§ 22-21-20. Definitions.

Currentness

For the purpose of this article, the following terms shall have the meanings respectively ascribed to them by this section:

(1) HOSPITALS. General and specialized hospitals, including ancillary services; independent clinical laboratories; rehabilitation centers; ambulatory surgical treatment facilities for patients not requiring hospitalization; end stage renal disease treatment and transplant centers, including free-standing hemodialysis units; abortion or reproductive health centers; hospices; health maintenance organizations; and other related health care institutions when such institution is primarily engaged in offering to the public generally, facilities and services for the diagnosis and/or treatment of injury, deformity, disease, surgical or obstetrical care. Also included within the term are long term care facilities such as, but not limited to, skilled nursing facilities, intermediate care facilities, assisted living facilities, and specialty care assisted living facilities rising to the level of intermediate care. The term "hospitals" relates to health care institutions and shall not include the private offices of physicians or dentists, whether in individual, group, professional corporation or professional association practice. This section shall not apply to county or district health departments.

(2) PERSON. The term includes individuals, partnerships, corporations, and associations.

Credits

(Acts 1975, 3rd Ex. Sess., No. 140, p. 382, § 1; Acts 1979, No. 79-798, p. 1461; Acts 1991, No. 91-548, p. 1010, § 1; Act 2001-1058, 4th Sp. Sess., p. 1044, § 1.)

Notes of Decisions (3)

Ala. Code 1975 § 22-21-20, AL ST § 22-21-20
Current through the end of the 2025 Regular Session. Some provisions may be more current; see credits for details.

End of Document

Code of Alabama
Title 22. Health, Mental Health, and Environmental Control. (Refs & Annos)
Subtitle 1. Health and Environmental Control Generally. (Refs & Annos)
Chapter 21. Hospitals and Other Health Care Facilities Generally. (Refs & Annos)
Article 2. Licensing of Hospitals, Nursing Homes, and Other Health Care Institutions. (Refs & Annos)

Ala.Code 1975 § 22-21-21

§ 22-21-21. Purpose of article.

Currentness

The purpose of this article is to promote the public health, safety and welfare by providing for the development, establishment and enforcement of standards for the treatment and care of individuals in institutions within the purview of this article and the establishment, construction, maintenance and operation of such institutions which will promote safe and adequate treatment and care of individuals in such institutions.

Credits
(Acts 1949, No. 530, p. 835, § 1; Acts 1962, Ex. Sess., No. 122, p. 157, § 1.)

Notes of Decisions (2)

Ala. Code 1975 § 22-21-21, AL ST § 22-21-21
Current through the end of the 2025 Regular Session. Some provisions may be more current; see credits for details.

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KeyCite Yellow Flag
Proposed Legislation

Code of Alabama
Title 34. Professions and Businesses. (Refs & Annos)
Chapter 19. Midwives. (Refs & Annos)

Ala.Code 1975 § 34-19-11

§ 34-19-11. Definitions.

Currentness

The following words and phrases shall have the following meanings, unless the context clearly indicates otherwise:

(1) BOARD. The State Board of Midwifery.

(2) LICENSED MIDWIFE. A practitioner who holds a certified professional midwife credential and is licensed by the board to practice midwifery.

(3) MIDWIFERY. The provision of primary maternity care during the antepartum, intrapartum, and postpartum periods.

Credits
(Act 2017-383, p. 1235, § 2.)

Ala. Code 1975 § 34-19-11, AL ST § 34-19-11
Current through the end of the 2025 Regular Session. Some provisions may be more current; see credits for details.

End of Document

KeyCite Yellow Flag
Proposed Legislation

Code of Alabama
Title 34. Professions and Businesses. (Refs & Annos)
Chapter 21. Nurses. (Refs & Annos)
Article 5. Advanced Practice Nursing. (Refs & Annos)

Ala.Code 1975 § 34-21-81

§ 34-21-81. Definitions.

Currentness

As used in this article, the following terms shall have the following meanings:

(1) ADVANCED PRACTICE NURSE. A registered nurse who has gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles and has been certified by the Board of Nursing to engage in the practice of advanced practice nursing. There shall be four categories of advanced practice nurses: Certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), certified registered nurse anesthetists (CRNA), and clinical nurse specialists (CNS). Certified registered nurse practitioners and certified nurse midwives are subject to collaborative practice agreements with an Alabama physician. Certified registered nurse anesthetists and clinical nurse specialists are not subject to collaborative practice agreements with an Alabama physician and are not subject to the requirements of Sections 34-21-82, 34-21-83, and 34-21-85 to 34-21-92, inclusive, and are prohibited from engaging in any of the acts or functions of a certified registered nurse practitioner (CRNP) or a certified nurse midwife (CNM) as established by this article and rules adopted under this article.

(2) ADVANCED PRACTICE NURSING. The delivery of health care services by registered nurses who have gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles as certified registered nurse practitioners, certified nurse midwives, certified nurse anesthetists, and clinical nurse specialists:

a. Practice as a certified registered nurse practitioner (CRNP) means the performance of nursing skills by a registered nurse who has demonstrated by certification that he or she has advanced knowledge and skills in the delivery of nursing services within a health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

b. Practice as a certified nurse midwife (CNM) means the performance of nursing skills by a registered nurse who has demonstrated by certification that he or she has advanced knowledge and skills relative to the management of women's health care focusing on pregnancy, childbirth, the postpartum period, care of the newborn, family planning, and gynecological needs of women, within a health care system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

c. Practice as a certified registered nurse anesthetist (CRNA) means the performance of or the assistance in any act involving the determination, preparation, administration, procedural ordering, or monitoring of any drug used to render an individual insensible to pain for surgical and other therapeutic or diagnostic procedures. The nurse anesthetist is qualified in accordance with Section 27-46-3 and is licensed by the Board of Nursing and functions under the direction of or in coordination with a physician licensed to practice medicine, a podiatrist, or a dentist, who is immediately available. Nothing in this paragraph shall be construed to restrict the authority of a health care facility to adopt policies relating to the provision of anesthesia and analgesia services.

d. Practice of clinical nurse specialist (CNS) nursing means the performance of nursing skills by a registered nurse who, through study and supervised practice at the graduate level and as evidenced by certification, has advanced knowledge and practice skills in a specialized area of practice, except that a clinical nurse specialist may not do any of the following:

1. Perform delegated medical acts or engage in collaborative practice as described in this article.

2. Perform any of the functions of a certified registered nurse practitioner or a certified nurse midwife as described in this article and the rules adopted under this article, whether or not performed within a collaborative practice relationship.

3. Prescribe drugs of any type. A clinical nurse specialist may perform nursing services permitted under this subdivision as an independent contractor.

(3) BOARD OF MEDICAL EXAMINERS. The State Board of Medical Examiners established pursuant to Section 34-24-53.

(4) BOARD OF NURSING. The Board of Nursing established under Section 34-21-2.

(5) COLLABORATION. A formal relationship between one or more certified registered nurse practitioners and certified nurse midwives and a physician or physicians under which these nurses may engage in advanced practice nursing as evidenced by written protocols approved in accordance with the requirements of this article or exempted in accordance with requirements of this article. The term collaboration does not require direct, on-site supervision of the activities of a certified registered nurse practitioner or a certified nurse midwife by the collaborating physician. The term does require such professional oversight and direction as may be required by the rules of the State Board of Medical Examiners and the Board of Nursing.

(6) COORDINATION WITH. When an anesthesiologist is not physically present, the working relationship between a physician, a podiatrist, or a dentist and a certified registered nurse anesthetist licensed to practice in this state. Each contributes his or her respective expertise in the provision of patient care, which includes the discussion of patient treatment, diagnosis, and consultation.

(7) JOINT COMMITTEE OF THE STATE BOARD OF MEDICAL EXAMINERS AND THE BOARD OF NURSING FOR ADVANCED PRACTICE NURSES. The Joint Committee of the State Board of Medical Examiners and the Board of Nursing for Advanced Practice Nurses shall mean and shall be a committee composed of all of the following:

a. Two physicians licensed to practice medicine in the State of Alabama.

b. One registered nurse licensed to practice professional nursing in the State of Alabama.

c. One licensed physician engaged in a collaborative practice with a certified registered nurse practitioner or a certified nurse midwife in the State of Alabama.

d. One certified registered nurse practitioner engaged in advanced practice with a physician in the State of Alabama.

e. One certified nurse midwife engaged in advanced practice with a physician in the State of Alabama.

(8) LEGEND DRUG. Any drug, medicine, chemical, or poison bearing on the label the words, "Caution, Federal Law prohibits dispensing without prescription" or similar words indicating that the drug, medicine, chemical, or poison may be sold or dispensed only upon the prescription of a licensed practitioner, except that the term legend drug shall not include any drug, substance, or compound which is listed in Schedules I through V of the Alabama Uniform Controlled Substances Act.

(9) PHYSICIAN or COLLABORATING PHYSICIAN. A doctor of medicine or a doctor of osteopathy licensed to practice medicine in Alabama who agrees in writing to practice in collaboration with one or more certified registered nurse practitioners or certified nurse midwives in accordance with the rules adopted by the State Board of Medical Examiners and the Board of Nursing.

(10) PRESCRIBE or PRESCRIBING. The act of issuing a written prescription for a legend drug.

(11) PRESCRIPTION. An order for a legend drug which is written and signed by a practitioner authorized by law to prescribe and administer such drugs and which is intended to be filled, compounded, or dispensed by a pharmacist.

(12) PROCEDURAL ORDERING. The ordering of the anesthesia plan, including the ordering of medications and tests before, during, or after analgesia or anesthesia in accordance with the anesthesia plan.

(13) PROTOCOL. A document approved in accordance with Section 34-21-87 establishing the permissible functions and activities to be performed by certified registered nurse practitioners and certified nurse midwives and signed by collaborating physicians and any nurse practitioners or nurse midwives practicing with those physicians.

Credits

(Acts 1995, No. 95-263, p. 464, § 2; Act 2001-239, p. 281, § 3; Act 2022-379, § 1.)

Ala. Code 1975 § 34-21-81, AL ST § 34-21-81
Current through the end of the 2025 Regular Session. Some provisions may be more current; see credits for details.

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