Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 22, 2023

The Honorable Joseline A. Peña-Melnyk
Chair, House Health and Government Operations Committee
Room 241, House Office Building
Annapolis, Maryland 21401

RE: HB 351 - Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section – Letter of Information

Dear Chair Peña-Melnyk and Committee Members:

The Maryland Department of Health (MDH) is submitting a letter of information for House Bill (HB) 351 - Health Occupations – Licensed Direct–Entry Midwives – Previous Cesarean Section. HB 351 will add a previous cesarean section (c-section; specifically, c-section which resulted in a confirmed low transverse incision and was performed at least 18 months prior to the expected date of birth for the current pregnancy) to the list of conditions that requires a Direct-Entry Midwife to consult with a health-care practitioner and share the recommendations of the consultation with the patient. HB 351 will also require that a Direct-Entry Midwife transfer care to a healthcare practitioner for patients with a history of c-section (except as specified above) or myomectomy (removal of fibroids from the uterus). Lastly, the bill requires that the State Board of Nursing, in consultation with certain stakeholders develop a planned out-of-hospital birth transport protocol for patients with a previous c-section.

The Committee on Obstetric Practice with the American College of Obstetrics and Gynecology (ACOG) considers a prior c-section delivery, fetal malpresentation, or multiple gestation, to be an absolute contraindication to planned home birth.[1] Specifically, for a prior c-section delivery, complications such as uterine rupture may be unpredictable.[2] A recent US study showed that planned home trial of labor after c-section (TOLAC) was associated with intrapartum fetal death rate higher than the rate for a trial of labor at hospitals (2.9 vs. 0.13 per 1,000).[3] ACOG recommends that a TOLAC be undertaken in facilities where there is the ability to begin an emergency c-section delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care due to the risks associated with the trial.

MDH believes it is critical to provide a consent agreement to a patient that informs them of the benefits, risks, and alternatives to the procedure being performed. The decision to offer and pursue a TOLAC in a setting in which the option for immediate c-section delivery is limited should be considered carefully by patients and their health care providers. When provided with full informed consent, the decision of the place and provider of birth should be left to the birthing parent and family.

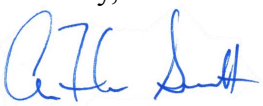
1. The American College of Obstetrics and Gynecologists.Committee Opinion. Number 697. April 2017. (Reaffirmed 2020). Planned Home Birth. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/04/planned-home-birth.pdf

MDH also notes that many home births result in hospital transfers due to intrapartum or postpartum complications. A review of 15 studies with data from 215,257 women found that 9.9% to 31.9% of home births were transferred to a hospital.[4] In Maryland, there are six counties (Caroline, Dorchester, Kent, Queen Anne's, Somerset, and Worcester) without a birthing hospital within county borders.[5] Two birthing hospitals, Peninsula Regional Medical Center and University of Maryland Shore Health at Easton, are the closest facility for 5 of the 6 jurisdictions (Caroline, Dorchester, Queen Anne's, Somerset, and Worcester), with Union Hospital of Cecil County being the closest facility to Kent County. On average, the distance from these counties to the nearest facility ranges from 18 to 36 miles, but individuals may need to travel farther depending on their location within the county.

The distance from these facilities highlights the importance of an informed consent discussion, so that the patient and family can understand the benefits, risks, and alternatives to the procedure. In that discussion, the patient and health care provider should consider the transport protocol for planned home births including geography, distance, and a timely method to transport to a facility equipped to treat patients transferred in emergency situations.

If you have any questions please contact Megan Peters, Acting Director, Office of Governmental Affairs, megan.peters@maryland.gov or (410) 260-3190.

Sincerely,



Laura Herrera Scott, M.D, M.P.H.
Secretary

2. Cox KJ, Bovbjerg ML, Cheyney M, Leeman LM. Planned Home VBAC in the United States, 2004-2009: Outcomes, Maternity Care Practices, and Implications for Shared Decision Making. Birth. 2015 Dec;42(4):299-308. doi: 10.1111/birt.12188. Epub 2015 Aug 26. PMID: 26307086.
3. Landon MB, Hauth JC, Leveno KJ, Spong CY, Leindecker S, Varner MW, Moawad AH, Caritis SN, Harper M, Wapner RJ, Sorokin Y, Miodovnik M, Carpenter M, Peaceman AM, O'Sullivan MJ, Sibai B, Langer O, Thorp JM, Ramin SM, Mercer BM, Gabbe SG; National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. N Engl J Med. 2004 Dec 16;351(25):2581-9. doi: 10.1056/NEJMoa040405. Epub 2004 Dec 14. PMID: 15598960.
4. Blix E, Kumle M, Kjærgaard H, Øian P, Lindgren HE. Transfer to hospital in planned home births: a systematic review. *BMC Pregnancy Childbirth*. 2014;14:179. Published 2014 May 29. doi:10.1186/1471-2393-14-179
5. https://mdmom.org/birthinghospitals