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January 27, 2022
The Honorable Shane Pendergrass
Chair, House Health and Government Operations Committee
House Office Building, Room 241
Annapolis, MD 21401
Re: House Bill 66 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: Support

Dear Chairman Pendergrass,
I am writing to you to urge your support of HB66.
I am a Certified Professional Midwife, licensed since 2020 in both Maryland and Virginia. I have experience supporting VBAC (Vaginal Birth After Cesarean) in the out-of-hospital setting since 2010, in the United States (Maryland, Virginia, and West Virginia), and in Germany and England.

As a licensed out-of-hospital birth provider in Virginia who can legally provide VBAC, my current VBAC success rate, albeit with a small sample size, is 100% with 0% maternal or infant morbidity and mortality in both the home and birth center settings. Incredibly, as an example of another targeted regulation used to restrict midwifery access, Virginia does not allow CPMs to carry lifesaving medications of any kind, to include Pitocin or IV fluids, yet gives consumers the choice to weigh their personal risks and benefits of pursuing any type of out-of-hospital birth with a CPM, to include VBAC.

Currently I am aware of one client who has moved from her home in Pennsylvania to her parents' home in West Virginia in order to receive care to prepare her for a home birth after Cesarean (HBAC), because of the "VBAC Ban" (refusal to provide Trial of Labor After Cesarean (TOLAC) in her local hospital. This is a relatively common scenario and one that does not improve safety.

If people want a VBAC, they will move mountains to have a VBAC, which implies the role of financial and social privilege in their ability to achieve one. This then creates further health disparities in Maryland where disadvantaged people will have no choice but to subject themselves to a repeat cesarean with its myriad health risks, to include hemorrhage, infection, hysterectomy and placenta previa. Many women with a cesarean scar in Maryland who want a chance at a vaginal birth, with an 99% chance of an intact uterus, now feel forced to attempt to give birth alone, or with an untrained attendant, or with a trained attendant who has to travel from long distances out of Maryland to an unfamiliar hotel or AirBnB to attend them. This does not improve safety, especially in the context of ACOG's (American College of Obstetrics and Gynecology) statement that VBAC "*be*

performed in a facility with the ability to begin emergency cesarean delivery within a time interval that best considers maternal and fetal risks and benefits with the provision of emergency care." This encompasses every single person who is in labor, not just people attempting a VBAC. If a hospital states that they are not ready to treat a cord prolapse, or nonreassuring fetal heart tones, or a maternal stroke, then they are not equipped to be performing any birth.

ACOG also states "*a successful VBAC has the following benefits: No abdominal surgery, shorter recovery period, lower risk of infection, less blood loss. Many women would like to have the experience of vaginal birth, and when successful, VBAC allows this to happen. For women planning to have more children, VBAC may help them avoid certain health problems linked to multiple cesarean deliveries. These problems can include bowel or bladder injury, hysterectomy, and problems with the placenta in future pregnancies. If you know that you want more children, this may figure into your decision.*"

How can we square this strong, compelling statement from ACOG with the fact that approximately 11% of people having a TOLAC in hospitals in Maryland achieve a VBAC (albeit without the corresponding maternal or infant health outcomes that the state has deemed not important enough to track, yet consider it so dangerous as to totally restrict access), while 60-80% of VBAC attempts are reported to be successful and safe for mother and child in the home or birth center setting?

Certified Professional Midwives in the State of Maryland are highly trained in out-of-hospital birth, a qualification that we must prove by virtue of the Maryland direct -entry midwifery licensure requirements which are more stringent than many other states' requirements for midwifery licensure, some of which allow VBAC in the out-of-hospital setting with CPMs.

Certified Professional Midwives who are qualified to be licensed in Maryland receive specific training in VBAC and in recognizing conditions that are deemed to be less safe for VBAC in the out-of-hospital setting, including assessing each individual for safety such as type of scar and pregnancy interval, and also trained to prevent, identify and treat the rare emergent situations such as uterine rupture. Uterine rupture, at a rate of 1%, is a much more infrequent occurrence than two other emergency complications; postpartum hemorrhage (3%) and neonatal resuscitation (5-10%), both of which are time-sensitive acute emergencies that CPMs are also well-trained to manage in the home setting, and which we are entrusted to manage under Maryland law.

CPMs are also recognized experts in providing informed choice information and communication to their clients. Healthcare consumers such as pregnant women also must be given the right to choose what is best for them, their babies and their bodies, and with Virginia and DC sitting nearby, currently giving consumers this informed choice to access out-of-hospital VBAC, along with many other states (see the Virginia informed choice document attached) it feels especially arbitrary for Maryland to have set such a state-wise boundary on a condition that has a very low rate of emergency complication and a high rate of safety and success globally. I have attached my VBAC informed choice document as an example of the information that out-of-hospital midwives provide to clients to help them make the right choice for themselves.

I am not writing to you for financial gain; I do not need the business of VBAC hopefuls as am fully booked with clients who wish to have a homebirth for myriad other reasons usually related to their deep dissatisfaction with their prior or current hospital-based experiences. I am writing to you as someone who sees and feels the trauma and desperation of people who wish to not be forced to gamble with their uteruses and the health of their future pregnancies with their extremely low chances of achieving VBAC in Maryland hospitals. Thank you for your time.

Sincerely,

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25. VBAC (VAGINAL BIRTH AFTER CESARIAN) PREVIOUS UTERINE INCISION OR MYOMECTOMY (8)

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. But if problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery. Because uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency. Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC outside of the hospital setting so review of prior surgical records is essential part of the evaluation.

RISKS

Maternal risks

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks

- Hypoxic Ischemic Encephalopathy
- Stillbirth

- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success

Increased Probability of Success
- Prior vaginal birth
- Spontaneous labor

Decreased Probability of Success
- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Maternal obesity
- Preeclampsia
- Short interpregnancy interval
- Increased neonatal birth weight

As required by the regulations for practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors that apply to me. I have decided to:

- ❑ Consult with a physician regarding my risk factors.
- ❑ Decline consultation with a physician regarding my risk factors.

Client_____ Date _____

Midwife_____ Date _____

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VBAC (Vaginal Birth After Cesarean) Informed Choice Document

VBAC (Vaginal Birth After Cesarean) has been shown to be safe in multiple studies and in a wide variety of situations. The American College of Obstetricians and Gynecologists (ACOG) has reaffirmed their position that VBAC is a safe option for women with one and sometimes two prior low transverse cesareans, provided they are supported and monitored appropriately (this is open to interpretation.)

There is no good data on the safety of VBAC with multiples or breech babies but ACOG has said it is also a safe option. There is no data on the safety of vaginal birth after uterine surgery other than cesarean; it is believed that the risk will be the same, depending on location and size of incision.

The success rate of VBAC is around 70-80%, with the success rate depending on previous vaginal delivery and the individual circumstances surrounding the prior cesarean and the current pregnancy.

Uterine Rupture

The unique risk in VBAC is uterine rupture. Several studies have found that the overall risk of any rupture of the uterus in women with one prior low transverse cesarean is .5-1%. This is the same overall risk as placental abruption, cord prolapse, and shoulder dystocia- risks that are generally accepted as worth taking in vaginal birth with an unscarred uterus. Very rarely (.012%), rupture can occur even in an unscarred uterus.

The signs of impending uterine rupture will generally become apparent before the actual rupture occurs and immediate transport from the home setting will be required. These include:

- Vaginal bleeding, blood in urine
- Sharp or unusual pain between contractions, differing from contraction pain
- Referred pain in chest or shoulder
- Labor dystocia
- Bulging of fetus into abdomen
- Sudden fetal position or station change
- Maternal shock: tachycardia, tachypnea, hypotension
- Fetal distress: sudden variable decelerations, bradycardia

Even in the rare case of uterine rupture, an even smaller percentage of these ruptures will be catastrophic or cause maternal or fetal morbidity or mortality. There have been no incidences of maternal death due to uterine rupture in the studies.

More often there will be a *scar dehiscence*. This is where the uterine layers separate partially or fully, but do not bleed, and the fetus does not prolapse into the abdomen or suffer any health effects. You will not immediately know if you have had a scar dehiscence if you have a VBAC, but there may be later effects of the scar dehiscence, which include painful periods, irregular bleeding, chronic pelvic pain, painful sex, and secondary infertility.

Home VBAC (HBAC)

Continuous electronic fetal monitoring (CEFM) is not available in the home setting, but intermittent auscultation has been shown repeatedly to be as safe as CEFM and supports the healthy, active, upright labor that contributes greatly to normal labor progress. CEFM has been linked to increased cesarean or instrumental deliveries, without much improvement in poor outcomes.

At home you will receive the one-to-one, continuous in-person care that helps providers notice early warning signs of dysfunctional labor or fetal distress, which has been named as the most important factor in the safety of VBAC. Mothers themselves notice signs of impending uterine rupture or problems with their babies well before monitoring equipment will. We will support you in being connected to your body and baby in this way.

While the ACOG calls for VBAC to be conducted in facilities that have immediate anesthesia and surgical capability, their maximum response time guideline for any obstetric emergency remains at 30 minutes, which is achievable in many home situations, especially when transport is carefully planned prenatally. The American

Academy of Family Physicians has noted that the ACOG "surgical team immediately available" guideline is no longer evidence-based, as the evidence has not shown a benefit or improved VBAC outcome with this limitation.

Some mothers plan to labor at home and then transport to hospital for the 2nd stage (pushing). While this option is sensible for many people, and certainly avoids the interventions that can impede healthy labor progress, it is not necessarily a safer option than planning home VBAC. The ACOG states that more than 90% of uterine rupture happens during labor, with most of these occurring around 4-5 cm dilation (the onset of active labor), and only 18% occurring during 2nd stage. Therefore, trained care provider attendance during labor, and client and partner awareness of the symptoms of uterine rupture or other complications, are more critical to ensuring safety than the actual place of birth.

Regarding labor induction, augmentation or pain relief: studies show that induction or augmentation with IV oxytocin (Pitocin) or with foley bulb **do not** significantly increase the risk of uterine rupture, nor does the use of epidural pain relief. Induction with prostaglandins is contraindicated.

Risks and Benefits

A successful VBAC birth has the fewest complications, while an *emergency* cesarean after laboring in a trial of VBAC has the greatest risk of adverse outcome (though still low) for both mother and baby.

VBAC

Benefits:

- Avoids or minimizes all the effects of abdominal surgery, to include infection, effects of anesthesia, scar healing, slow recovery, increased blood loss. thromboembolism, bladder and bowel injury (see below)
- Lowers several risks to future pregnancies (see below)
- Protects breastfeeding initiation

Risks:

- The overall maternal and fetal risk in a VBAC labor and birth is comparable to the risks of labor and birth in a normal first pregnancy (typical risks of normal vaginal birth plus a .5-1% risk of uterine rupture).
- Increased risk of endometritis and need for blood transfusion
- Increased incidence of hypoxic ischemic encephalopathy (HIE) (7.8/10,000) mostly associated with uterine rupture

Repeat cesarean after trial of labor (intrapartum cesarean)

Benefits:

- Reduced risk of neonatal respiratory problems, decreasing with longer gestational length
- Hormonal stimulation of maternal and fetal systems

Risks:

- Intrapartum cesarean in the studies was most often due to uterine rupture or dehiscence, and also led to an increased need for hysterectomy, transfusion
- Elevated risk of uterine infection (767/10,000 vs 116/10,000)

Elective prelabor repeat cesarean (ERCS)

Benefits additional or different to intrapartum repeat cesarean:

- Care team and specific cesarean options can be planned
- Reduces the risk of prelabor stillbirth when scheduled at 39 weeks (an increase in the rate of stillbirth to 10 per 10,000 in VBAC gestations past 39 weeks)
- Reduces the risk of uterine rupture and the intrapartum stillbirths or HIE (hypoxic ischaemic encephalopathy) associated with it to 1 in 10,000 or less

- Reduces the risks associated with intrapartum cesarean: longer recovery time, maternal and fetal infection

All cesarean births involve a greater risk of:

- Increased risk to future pregnancies: placenta previa, accreta/increta/percreta, ectopic pregnancy, secondary infertility, hysterectomy. These risks increase in incidence after each subsequent cesarean.
- Increased surgical risk: anesthesia problems, bladder and bowel injury, pelvic adhesions leading to chronic pelvic pain, blood loss leading to shock and transfusion, wound infection, thromboembolism
- Increased maternal mortality (13 in 100,000 vs. 4 in 100,000 for VBAC)
- Increased risk of neonatal respiratory problems, generally attributed to decreased lung maturity at 39 weeks without benefit of intrauterine stimulation (4-5% vs 2-3% in VBAC)

Safe Home Care

Those who wish to have a HBAC in this practice should ideally have **one or two lower transverse** uterine incisions and no other health or pregnancy concerns at the time of labor onset.

Copies of your prior birth records are required. A **thorough records review** will be performed with you to understand the factors leading to your prior cesareans, and to help us plan for the best approach to the upcoming birth.

Because it is known that cesarean sections can affect the way a placenta implants into the uterus in the following pregnancies, a **sonogram** will be offered in the third trimester (by 36 weeks) to identify the location and implantation of the placenta.

Your HBAC labor should ideally begin spontaneously at term gestation and be attended at an earlier stage for intermittent monitoring of approximately every 15-30 minutes in 1st stage. Transport to hospital will be initiated quickly upon identification of any abnormality or abrupt change in maternal or fetal clinical picture.

We offer natural methods of induction that are safe for VBAC labor (foley bulb, membrane sweeping, herbs and homeopathics, nipple stimulation, acupuncture). We do not offer oxytocin or prostaglandin induction or augmentation.

You may request a transfer to hospital care at any time in your pregnancy or labor. You must freely seek to have a VBAC at home and understand and be comfortable with the potential risks of VBAC. You must be willing to transfer to the closest hospital (10-20 minute transport time) upon development of complications and upon midwife guidance.

Indications for emergency transport include: rise in client pulse; change in fetal heart tones (tachycardia or bradycardia); change in fetal movement; pain at uterine scar site; abnormal uterine pain, tenderness, laxity or rigidity; abnormal vaginal bleeding; a slowing or stop in contraction pattern; vomiting; fainting or altered mental status; fetal parts visible in abdomen.

CLIENT VBAC INFORMED CONSENT

Please initial the following statements that reflect your genuine belief, desire, and knowledge.

___ I understand that having had a previous cesarean section, there are greater statistical risks for me to give birth, including but not limited to uterine rupture, which can be a life-threatening condition for both client and baby.

___ I agree to research uterine rupture: what it is, why it is a problem.

___ I understand that attempting a VBAC will increase the statistical risks of birth for both my baby and myself.

___ I understand that VBAC attempts sometimes result in repeat cesareans.

___ I understand that my midwives would not recommend a VBAC out of the hospital if my placenta is implanted at the site of my cesarean scar (determined by ultrasound) or if I have had a complicated recovery from my cesarean(s) which could include prolonged uterine infection or lack of rest to heal afterwards.

____ I understand that I have the right to a repeat cesarean at any time and that my midwives would support me in that choice.

____ I understand that transport to the hospital would be necessary for a cesarean section and that it could increase the time it takes to assemble a surgical team for a cesarean.

____ I have accurately filled out an Emergency Transport Form and reviewed it with my midwife.

____ I agree to NOT use any form of uterotonic on my own, even natural ones (i.e., castor oil, herbs for induction, breastpump, etc). I understand that a VBAC labor that needs to be induced for any reason may be safest in the hospital setting.

____ I understand that the decision to have a repeat cesarean section or attempt a VBAC is my own. I also acknowledge that the desire of my midwives is to help me achieve my goal of the healthiest possible birth experience, and agree to be honest in communicating with them regarding my physical and emotional health regarding my pregnancy, labor, and birth.

___ I understand that in deciding to have a VBAC I am agreeing to work to nourish myself completely and practice healthy lifestyle habits including but not limited to: drinking plenty of clean water; eating a complete diet with ample veggies, protein, and low sugar; avoiding chemical sweeteners and other chemical exposure, etc; obtaining adequate rest and exercise.

In addition, I agree to the following:
I have read and discussed the above information regarding vaginal birth after previous cesarean (VBAC) and have had the opportunity to further research, ask questions and seek alternatives including second opinions regarding this subject. I have discussed and understand the alternatives, risks and benefits with my midwife. I assume responsibility for my health care choices including by not limited to: the place of birth, care provider of my choice and for birth outcome and health of my babies, which has no guaranteed outcome.
I have been informed that my midwives do not have access to, or carry medical malpractice insurance for VBAC. Despite the increase in risks, I make the choice to birth my baby out of the hospital with a midwife, believing this is a reasonable and responsible decision for my baby and myself.

Client Signature_____ Date: _____

Printed Name _____ Date: _____

Midwife Signature _____ Date: _____